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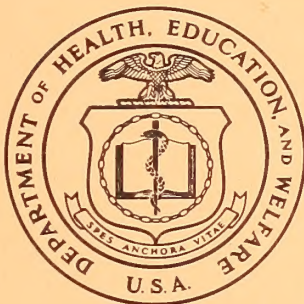
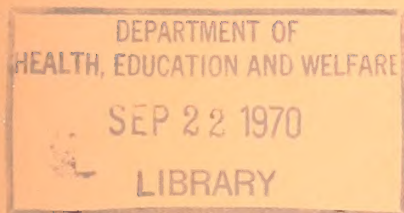
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UTILIZATION REVIEW

APPENDIX E



FEDERAL HEALTH INSURANCE FOR THE AGED

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social Security Administration

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
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<u>New Material</u>	<u>Page No.</u>	<u>Replaced Pages</u>
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Transmitted is Appendix E to the State Operations Manual, which is devoted entirely to utilization review. This appendix is a supplement to the instructional material contained in the 2500 sections of the manual, and does not supplant any of that material. The aim of the appendix is to supply useful examples and discussions of a practical nature on currently existing practices and procedures, and to furnish copies of UR forms and formats in present use. Since systems for reviewing continuous extended duration cases have been fairly well worked out, we have not discussed these.

One of the least understood areas in utilization review concerns special studies on a sample or other basis. Since an understanding of the entire sample review area is essential to the surveyor, Part 1 should be carefully studied and discussed among State agency surveying staff. We strongly recommend that the entire Appendix be used as a discussion tool in your contacts with providers' utilization review committees and that reference copies be left with the committees wherever the survey shows that the committee could benefit from studying its contents.

While Part 1 of the Appendix discusses different methods of performing the reviews on a sample or other basis in hospitals, many of the ideas and forms can be adapted profitably by ECF committees. Part 2 discusses briefly some of the commercial organizations, and their printed materials helpful to utilization review committee activities. It should always be stressed, however, that these organizations do not actually perform utilization review but merely furnish supplies and

services. The Federal Government does not endorse any of these private organizations and this section is furnished for information only. The variety of forms and formats discussed in Part Three and further illustrated in the Examples can be useful not only for sample reviews, but also for reviews of continuous extended duration cases. The examples of written minutes may prove helpful to committees having problems along these lines.

Thomas M. Tierney, Director
Bureau of Health Insurance

APPENDIX E
Utilization Review

PART ONE

Techniques for Performing Special Studies on a Sample
or Other Basis in Hospitals

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We wish to express our appreciation to the following individuals and organizations who have kindly permitted the reproduction of examples, without which this Appendix could not have been written:

Beverly C. Payne, M.D., University of Michigan Medical School,
Department of Postgraduate Medicine, Ann Arbor, Michigan.
(Letter dated November 11, 1969.)
Examples A-1, C-1, D-8

Paul M. Lewis, M.D., Executive Director, and Judith Weilerstein,
Medical Record Consultant, The Hospital Utilization Project,
Pittsburgh, Pennsylvania. (HUP)
(Letters dated May 28, 1969 and November 10, 1969.)
Examples A-2, C-2, C-3, C-6, D-4, D-5

Vergil N. Slee, M.D., Director, Commission on Professional and
Hospital Activities, Ann Arbor, Michigan (PAS-MAP)
(Letters dated November 12, 1969 and December 5, 1969.)
Examples B-2, B-3, C-4, C-5, D-3

William R. Skelley, Vice President, and George Mikelbank, Director,
Provider Utilization Department, Hospital Service Plan of
New Jersey, Newark, N.J. (Blue Cross-Blue Shield)
(Letters dated November 10, 1969, January 27, 1970, February 16,
1970, May 26, 1970)
Examples B-1, D-7, E-1, E-2

Michael H. Goldman, Assistant to the Executive Director, California
Medical Association, San Francisco, California
(Letter dated November 26, 1969.)
Example F-1

John E. Adams, M.D., Chairman, Utilization/Audit Committee,
Greater Baltimore Medical Center, Baltimore, Maryland
(Letter dated April 27, 1970.)
Examples A-3, D-2, D-6

Arnold B. Kurlander, M.D., Executive Director, and Alvin M. Powers,
Assistant Director, Sinai Hospital of Baltimore, Inc. Baltimore,
Maryland
(Letters dated November 11, 1969 and April 16, 1970.)
Examples C-7, C-8, D-9

Part 1

Techniques for Performing Special Studies on a Sample
or Other Basis in Hospitals

I. Sample or other basis review in contrast to extended duration
review--Definition

The Conditions of Participation stipulate that two types of utilization review be performed: Extended duration review and sample or other basis review. The "Reviews" standard of the conditions of participation requires that reviews be performed on a sample or other basis of admissions, durations of stay, and professional services rendered with regard to the medical necessity of these services.

The extended duration review stresses the examination of an individual patient's length of stay.

The special study on a sample or other basis concentrates on the facility's practices in patient care, both administrative and medical practices being possible subjects for study.

The following sequence outlines our concept of the steps constituting such a special study:

1. The physicians of the committee are alerted to a problem resulting from a faulty pattern of care; something is wrong in the facility's operation. They define the subject for the study, i.e., timing of diagnostic workups, or appropriateness of emergency admissions. Once the subject for review has been selected, then the number of cases in the study category becomes a matter of concern: whether to include all cases, or whether to take only a "sample" which may be defined as a proportion considered to be representative of the entire universe of cases.

2. Next the committee conducts the special study, utilizing the services of clerical and allied health personnel as much as possible to collect and collate the data, analyze it, and summarize their findings of fact.

3. The findings are reported to the full UR committee.

4. A formal report including a summary of facts, findings, conclusions and recommendations is formulated and presented to the medical staff.

5. The medical staff takes corrective action with reference to faulty practices of its members as reflected in the study. It refers findings to be corrected administratively to the governing body and the administrator.

6. At a future date a follow-up study is performed to see whether the faulty practice has actually been corrected and the desired results obtained.

Use of the phrase "sample reviews" for these special studies favors attention to sampling methods for selection of individual cases which in many facilities are reviewed on a case by case basis. Use of various alternative terms such as "general (sample) review" or "medical audit" may be more meaningful to some providers of care.

A. Special studies on a sample or other basis contrasted to extended duration reviews

The special studies differ from extended duration reviews in a number of respects:

1. More variation in subject considered.
2. More variation in period of time for conducting the study.
3. More variation in selection of cases.
4. Different basis for the number of cases reviewed.
5. Individual cases are reviewed as representative of a group of cases in order to look for trends, common factors, patterns, common problems, etc.
6. Data should be collected and used for comparisons.
7. Final reports provide meaningful support for resulting recommendations.
8. More varied benefits of broader scope may result with this more flexible approach.
9. Follow up of recommendations differs in emphasis. In continuous extended duration cases the emphasis is directed toward individual situations, whereas in sample reviews the emphasis should be on correction or modification of patterns of care.

B. Types of "sample" reviews and broad purposes of each

Current regulations specify two rather distinct types of general reviews, the special study (which is considered in this appendix) and the review of recertifications.

1. The purposes for the special study include the identifying and analyzing of patterns of patient care rendered in the facilities, considering the services available, the use of these services, and

the needs of the patients for these and other services in order to facilitate the providing and the rendering of adequate and appropriate care to patients in facilities.

2. In contrast, the review of a group of recertifications should consider the quality, or the adequacy, of recertification material. Attention should be given to the inclusion or lack of inclusion of indications of reason for continued stay, services required and rendered, and expected stay (discharge plan).

II. Selection of a study project for special studies; reasons for study; possible topics

Before a committee begins any review activity, it should first set a goal, since a great deal of time can be needlessly expended on fruitless review when a committee goes through a number of cases at every meeting simply "to comply with the law." The same time can be expended productively and more interestingly with the critical and purposeful examination of assembled data or patient charts selected for review because of some facet other than usual. The results of the utilization review functions can be both meaningful for and beneficial to the facility and its patients.

The reason for selecting a study subject should be known. Identification of an "unusual experience," awareness of a problem, and follow up of previous study findings, etc., are some of the possible bases for selection of a specific subject.

Basically, the utilization review process may encompass screening aggregate data to identify the unusual experience; case review to identify faulty practices and procedures; and administrative review, on the basis of which operational modifications can be made.

Comparisons can be made between hospitals or between physicians, bearing in mind that the process is not intended to be punitive; its goals and purposes are educational, corrective and fact-finding.

While the following list of topics for the utilization review committee is by no means comprehensive, it is suggested as a starting point for those committees which want to begin purposeful review. Additional topics are mentioned under each of the areas to be covered on general reviews, discussed below.

At this point a word of caution should be given to committees just beginning special studies: Do not undertake too many studies at one time. Each facility must review its own resources to perform studies. A large hospital may have subcommittees on each service

performing studies. A committee for a small hospital should concentrate its resources to perform one meaningful in-depth study at a time.

DIAGNOSTIC LABORATORY AND RADIOGRAPHIC PROCEDURES

Cases with urine positive for albumin but without a repeat urinalysis or kidney function test

Cases with urine positive for sugar but without blood sugar determination

Pneumonia or pneumonitis - all cases - without chest X-ray or c.b.c.

Elective surgical cases (hernias, gall bladders, vein ligations, hemorrhoidectomies, etc.) going to surgery with hemoglobin less than 10 grams

Patients under age 40 undergoing surgery, with a diastolic pressure of 100 mm. or greater and no ECG

Coronary occlusions without ECG's

Preoperative investigations in appendectomies, etc.; include urinalysis, hemoglobin estimate and white blood count

The frequency with which diagnosis could have been made on an outpatient basis with admission specifically for therapy

Time consumed in obtaining preoperative X-ray and laboratory studies

Delay in use or overuse of X-ray, laboratory, and other diagnostic and therapeutic services

Evening and weekend coverage in laboratory and X-ray

Consideration of unnecessary utilization of laboratory, X-ray and other ancillary services

All undiagnosed cases

BLOOD

Hemorrhoidectomies, T&A's, vein ligations receiving blood transfusions

Use of whole blood

All one-unit transfusions

All cases of anemia receiving blood

DRUGS

Antibiotics

T&A's receiving antibiotics

Hernia - all cases receiving antibiotics

Antibiotic utilization where not indicated: clean surgery
(gastrectomies, hernia repair, vein ligations) - not infections;
newborns without infections (excluding premature births)

IV Fluids

Congestive heart failure cases receiving IV fluids

PROCEDURES

All neonatal deaths with breech deliveries

T&A's with postoperative complications (hemorrhage, infection)

Arrangement for consultations

Delay in consultation and referral

Analysis of cases indicating delay or neglect in obtaining consultation
Evaluation of cases involving delays in transfer to another service

ADMINISTRATIVE PROBLEMS

Composite lengths of stay, preoperative and postoperative, by diagnosis

Short stays (1-3 day admissions); reasons for admission, services
needed, alternate ways to meet needs

Excessive length of inpatient stay

"Customs in the community" or "Habit patterns" in handling specific
types of cases:

Scheduling of specific radiographic studies

Procedures for obtaining laboratory specimens and reporting results

Coordination of admitting office procedures with operating room
scheduling

Relationship of day of admission to preoperative stay

Operating room scheduling

Differences in length of stay and per diem costs for private and ward patients

Flow of requisitions and reports

Consideration of unnecessary hospital admissions

Emergency room admissions (but not for a limited case-by-case review for policing purposes)

III. Study Design

The utilization review plan need not specify study design. Naturally, each type of study will be structured according to its subject matter. Much time and energy can be saved and better results obtained by early consideration of the reasons for the study and the data which would be meaningful and should be accumulated.

A different design will be needed for comparative studies on a diagnostic basis (i.e., acute coronary occlusion) for example, than will be needed for a broad topic such as improving utilization of the surgical suite. Some of the studies may be able to utilize the services of allied health and administrative personnel to do the preponderant amount of the research and analysis, thus permitting the physicians of the committee to make final judgments, draw conclusions, and formulate recommendations.

The regulations require that the UR committee continuously be engaged in studies. However, the studies need not always cover the same period of time, nor must one be completed before another is begun.

While the following suggestions can help in performing studies of medical care, the purpose of these studies is to have an impact on the patterns of patient care. Unless action is taken on the recommendations made as a result of these studies, the entire process results in an academic exercise.

Frequently committees encounter difficulty carrying out the general reviews because they are unfamiliar with effective mechanisms to perform these reviews. Mechanisms can be established to review the records of patients who are still in the hospital (concurrent review) or the records of discharged patients (retrospective review). Both concurrent review and retrospective review should be considered in planning studies. Retrospective reviews are never considered by many facilities.

The advantage in performing concurrent review is that corrective action pertaining to individual patients can be taken while the patient is still in the hospital. However, since it is difficult to ascertain

in advance the outcome or effect of the treatment on a particular patient while he is still undergoing treatment, it is much easier to review cases retrospectively after discharge, when effects and alternate methods of treatment are more readily discernible on viewing the entire patient record.

The study can be designed by the physicians of the committee so that the medical record department performs the basic data collection, tabulation and summary, using either personnel in the department or computerized data services such as PAS-MAP, which of course must be further summarized for presentation to the committee. (For illustration of available data collection forms, see Examples C1, C2, C3, C4, C7, and C8.) It is recommended that the committee set down criteria for selection of cases for the study and the acceptable norms or limits of the subject matter to be studied in an objective manner so that the data can be screened for selection and for meeting qualitative or quantitative criteria if possible by medical record department personnel. These personnel should summarize the data before presenting it for analysis and review by the UR committee. The administrator should assure that such clerical assistance as the committee needs is also available to work on preliminary processing of the study material. Various allied health personnel (nurse, pharmacist, physical therapist, dietitian) may be asked to perform evaluative review of the data, as needs of the study dictate. General studies can be conducted by specified departments and be acceptable for utilization review. The committee may also utilize the services or reports of studies performed by other committees such as infections control or pharmacy and therapeutics as source data on which to base utilization review.

When the summarized data is presented to the committee, the members then proceed to analyze the problem and its ramifications, and search for solutions. The committee's initial task may be to identify and analyze the patterns of care and deviations from the anticipated pattern. When a subcommittee performs the special study function, it will report its findings with recommendations to the full UR committee. The UR committee's next action (on the basis of their findings which relate to the patterns of care in the institution) is to make recommendations and report them to the medical staff and the administration. It is the responsibility of the staff and the administration to consider and take action on these recommendations so that subsequent follow-up studies by the UR committee will reflect the needed improvement.

Example of a Special Study: A hospital's UR committee decides to study management of acute coronary occlusions, stressing myocardial infarctions. The medical record librarian meets with the two physicians assigned to the study, bringing with her a copy of the "Record" entitled "Acute Coronary Occlusion: Its Management in North Carolina" (see Example D-3). They review the items on pages 4, 5, and 6,

and ask if she can obtain similar data for their hospital. Using the latest coded diagnostic listing (see Example C-5) she points out all the data available under ICDA code 420.1. In demonstrating use of the data, she comments that if item 29 is coded A, S or B, then item 37 should usually be coded R (repeat urinalysis when admission sugar and/or albumin are positive). The physicians instruct her to set up the study to delineate the hospital's pattern of care as the first phase; she is to use the items appearing in the article, and use all cases including deaths for the preceding three months. She will show two categories (all coronaries, coronary deaths) for each items, with a breakdown of number and percentage for each of the two categories. The physicians then discuss what the hospital's standard should be, such as: EKG-100% of cases, blood pressure on admission-100%, CBC-100%, urinalysis-100%, chest X-ray-100%, repeat urinalysis when admission sugar and albumin are positive-100%.

In the second phase of the study, the physicians compare the librarian's findings with their desired standards. They find that 90 percent of the cases have EKG on admission and prior to discharge. Accordingly, phase three, they next direct the librarian to use special study criteria (Example A-1) and abstract sheet (Example C-1) for the 10 percent of the cases that fall outside the projected standard. The pattern also disclosed that most patients stayed 21 days; the 20 percent staying 26 and 27 days were considered to possibly represent overstay, since there were no significant complications. As a concurrent study, the librarian is requested to set this study up also, using the same forms on which to record the basic data. Utilizing the patient's chart, the medical record department employees complete entries on the designated abstract form as far as "Evaluation," which is completed by the submittee physicians. The completed forms are then tabulated and summarized by the record librarian (see Example D-4) with the assistance of the physicians. The subcommittee present their report at the next UR committee meeting (see Example D-7); after discussion, the full committee votes to present recommendations based on this report at the next medical staff meeting (see Example E-2).

A. Focus Areas

Since a great deal of expense in terms of the time of personnel involved can be invested in a study, the committee should carefully select those areas for investigation which they feel will be the most productive for their hospital. Because of variance in seasonal, economic, and social factors, the hospital staff in a given locale can usually predict or estimate the peak patient load for a specific diagnosis. Thus, a staff can draw on its combined experience as to what types of cases will be available in quantity for study at a particular time. A specific study may consider admissions, length of stay, and also the services rendered, or may look at only one or two of these aspects or at other aspects alone or in combination. Examples of studies are given in each of the required categories.

1. Admissions

The study design should define what is meant by "admissions" for the purpose of the study.

Criteria should be established by the committee either on the basis of its own experience or utilizing predetermined criteria compiled by other committees such as those at the University of Michigan (Examples A1 and C1) or the Hospital Utilization Project (Examples A2 and C2). The criteria should set forth specific indications for admission such as diagnosis established, and history and symptomatology leading to admission.

The value in this area is not in examining individual cases, but rather in taking blocks of cases (e.g., on a diagnostic basis) to ascertain the pattern of care at the facility. Once the pattern has been delineated, then the cases which are deviant could be critically examined. If the committee finds many deviant cases, they will report this fact to the medical staff, making suggestions or recommendations to correct the faulty practices. Some problems may require administrative intervention.

Studies of emergency admissions also should examine the pattern and not be confined solely to necessity for admission in the individual case. Comparison and consideration of entire groups of cases will yield the most benefit in pointing out areas needing medical staff or administrative action. The medical staff may have a functioning admissions committee which supervises the need for admissions and sets up classes of admissions (Emergency, Urgent, Routine or Elective) with criteria defining need for admission under each category. In such situations, copies of the admissions committee's studies and recommendations should be available to the UR committee for any further or spin-off studies they may decide to undertake. Either patients currently in the hospital or the records of those discharged can be used in the study.

2. Duration of Stays

Many committees have commented that a single day established to begin a period of continuous extended duration is not really satisfactory as a means of preventing unnecessary hospital stays. Bearing this comment in mind, the general review of duration of stays should not necessarily concentrate on the long-stay cases, since a review of short-stay or even those stays falling within normal limits might prove just as productive in discovering practices which need correction. Some examples of consideration of length of stay in general studies include those focusing on a number of areas (e.g., a study of selected diagnosis), as well as studies considering only duration of stays (e.g., study of 1-3 day admissions).

An initial study might compare recent listings of lengths of stay by diagnoses (see Examples B1, B2, B3) with the local hospital's experience for a particular diagnosis, for a specific time period (previous month or quarter or year). Medical record personnel can compile data, based on predetermined criteria supplied by the committee, on such individual factors as preoperative and postoperative lengths of stay, complications such as infections or concurrent diseases extending usual stays, etc. The committee may note emergent patterns which are causing otherwise usual stays to become extended, and then will make its recommendation to the appropriate correcting entity, the medical staff or the administration. Selected categories of diagnoses and procedures will have relatively short periods of extended duration. Recommendation of the length of the period of continuous extended duration for these individual categories might be a result of a general study of all short-stay cases.

The committee may decide to review all short-stay cases and define a short stay as 3 days or less of hospital stay. Using this method for selecting cases, it might be very time consuming for the committee or its clerical help to fill out abstract forms on these cases. Since the medical record would not be too thick, the actual record could easily be reviewed. The review of short-stay cases need not be limited to those diagnoses which usually result in a longer stay. The primary concern of such a review might be to determine the actual necessity for admission for these cases. Initially, it might be essential to review all short-stay cases. Based upon its experience, the committee could develop a set of selection criteria which would indicate those cases that should be reviewed. Of necessity, this type of review would be performed on records of discharged patients.

3. Professional Services Rendered

By "professional" services, we mean more than physician services. The aspects of care rendered by laboratory personnel, physical therapists, nurses, and the statutory requirement for review of drugs and biologicals used are included in this category. A better term might be "hospital services," so that the committee understands that all aspects of patient care should be subject to its scrutiny. In Example A1, Criteria for Acute Myocardial Infarction, the "Services Recommended" sections of Laboratory, Roentgenology and Special Procedures could form the basis for special studies. In Example A2, Criteria for Cholecystitis and Cholelithiasis, the "Hospital Services Required" areas as outlined could be used similarly.

The review of professional services furnished with respect to the medical necessity of the services and for the purpose of promoting the most efficient use of available facilities and services may be grouped into several general areas from which studies can be selected. The following categories suggest only a few of the many topics which a committee will want to investigate.

a. The availability and use of necessary services. This includes such services as diagnostic procedures in the clinical laboratory and radiology, and therapeutic services such as physical therapy, special diets, etc. The committee's study of how many treatments and tests have to be done under arrangements with others might lead to a recommendation that some necessary but hard to get or expensive services be shared with neighboring institutions.

The use of services - underuse, overuse, appropriate use - is an area which can profitably be investigated and is one which can be of obvious benefit to any facility.

The availability and use of consultants could be studied and recommendations made. Reviews of the findings of such committees as infections control or pharmacy and therapeutics may reveal areas of drug utilization needing further attention. Areas where proper utilization could be investigated include problems involving: in infections control, the overuse or underuse of antibiotics, and improperly prepared intravenous solutions with additives; and adverse patient reactions resulting from combinations of drugs, and alteration in the result of a laboratory test due to the patient's taking a drug before testing.

b. The timeliness of scheduling of services. Problems with scheduling and delays in use of operating rooms are common to most hospitals; see the discussion of ways to study these problems by Shindell and London in "A Method of Hospital Utilization Review." Delays in requesting and accomplishing consultative examinations, the order in which laboratory and radiology procedures are scheduled and any resultant delays in testing, and similar diagnostic and therapeutic procedures could be studied. Delays resulting from weekend or holiday admissions and lack of covered laboratory services could also be studied.

c. The timeliness of reporting. The medical record audit could be coordinated with this study. Delays resulting from tardy posting of test results, or other diagnostic and therapeutic procedures, and from illegible and incomplete postings in the record, could be studied.

d. The adequacy of the service. Is it being delivered in the right amount, what has been its effectiveness as reflected in the cases studied.

EXAMPLE: As the committee proceeds into the study of a service or area of the facility it will undoubtedly discover aspects of that subject which require further review or investigation. As an example of what the committee might pursue, if it chose to review physical therapy, members might look for patients receiving physical therapy who do not need the service and, conversely, those not receiving the

service who might benefit from it. In addition they might review the indications for physical therapy and study those situations when it is used inappropriately. As the result of this study the committee might decide to recommend that guidelines be drawn up outlining indications for physical therapy. They may also decide to review the timeliness of physical therapy and the quality of the services provided.

B. Selecting an Adequate Sample

Of more importance than the sampling method is the adequacy of the size of the sample for the specific study. Too exact a definition of a sampling method in the utilization review plan can limit the studies which can be performed. The utilization review plan should permit various types of general studies with consideration of cases as a group, and thus allow comparisons of cases along with the accumulation and use of data. For example, the review could encompass all admissions or discharges for a certain period each month (first 7 days), or a review of percentage (10%) or estimated proportion (one out of every ten admissions).

Generally, in selecting a universe of cases to be considered in a study, the larger the number of available cases the smaller need be the proportion of cases selected for the sample. When the hospital has 100 or fewer cases falling in a given category, the committee will probably want to include all cases for a 100% sample, since fewer cases might lead to questionable generalizations. If there are fewer than 50 cases in a category, it would probably be advisable to use an external base or standard for comparison, because of the limited experience represented in this total universe of cases. Where a large hospital might admit 1,000 coronaries in any month, and a sampling of 50 could be representative of its universe, the same would not hold true of a hospital having a total of 1,000 admissions for all purposes in a year. If the small hospital wanted to study some aspect of its coronary care, it should use all coronary admissions for the year and perhaps compare those for a two or three-year period with external norms supplied by intermediaries or other statistical-based organizations. Hospitals which keep cumulative statistics on a daily and monthly basis by medical and surgical service, or by broad disease classifications, will have a basic idea of the size of the general universe. Narrowing such figures down to a specific diagnostic universe can be done by using the indices of the medical record department or computer-index listings prepared by such subscription services as PAS-MAP and HUP (see Examples C5 and C6).

The specific number of cases selected may vary from study to study, but should be representative of the quantity of work done at that particular hospital. The California Medical Association has suggested a method of selecting a satisfactory number of cases, which may prove

adequate for the small hospital unable to employ sophisticated statistical concepts of case selection. However, committees for hospitals served by fewer than four physicians may wish to use 100% samples, when the total sample size can be easily handled. It should be borne in mind that the method quoted is only one of many valid statistical ways to take a sampling. (See Example F1.)

1. Diagnostic Basis

One method of determining patterns of care for patients is to review on a regular basis a number of cases within the same diagnosis or diagnostic grouping. Since treatments and professional services rendered are based on specific diagnoses, it follows that studies intended to elicit patterns of care for groups of patients are most profitable when based upon specific diagnoses. (This could result in a review of a single diagnosis each month or every two months.) In a large hospital the records of the last 40-50 patients (or in a small hospital all patients discharged during the designated time period) having the diagnosis under question might be abstracted, summarized by the medical record department, and reviewed by the committee. It is helpful in this type of study to have the committee either specify their own criteria, or adapt established professional standards to their own institution, which can be used to evaluate the care being given to all patients with the particular diagnosis. (See Examples A1 and A2 for criteria, C1 and C2 for worksheets.) These studies help to determine the patterns of care actually being given in an institution, and allow the committee members to ascertain to what degree their standards for high quality care are being met. An advantage of this type of study is that record department personnel may be able to perform the data extraction or summaries (see Examples C3 and C4) (or can utilize data collection services such as PAS-MAP or HUP for extractions and summaries), and can make up graphic or statistical presentations for the utilization review committee's consideration. Comparisons of utilization by year, by service, by age, etc. can also be made from data summarized by record department personnel for analysis by the committee (see Examples D1, D2, D3, D4, and D5).

2. Unstructured Percentage

When reviewing isolated individual cases, it is difficult to uncover patterns of care for groups of patients. Therefore, in order to derive the greatest benefit from this type of review, the committee should determine in advance specifically the problem they wish to study, such as: lapse of time following admission before diagnostic procedures (laboratory tests or X-ray examinations) are begun; lapse of time from admission to time of surgical procedure; delays resulting from the order in which tests are performed; diagnostic procedures which could have been done on an outpatient basis prior to or without admission. Because hospitals have different problems,

committee members will want to keep these examples in mind as they review cases with particular diagnoses, to help them in identifying problems which are applicable to their particular hospital.

C. Reporting Conclusions

General: The three phases of reporting may appear combined in one report, but because each represents a separate step of the analytical process each will usually appear as a separate document.

1. Summarization

Once the data has been tabulated and summarized by the medical record department or administrative personnel to present to the committee members assigned to make the study, it should be carefully analyzed by the committee (see Examples D7, D8 and D9). The summary should present the basic reason for the study, state the findings (e.g., by listing the number of cases studied, those meeting the criteria and those exceeding the criteria), and any conclusions the committee may have rationalized on the basis of these findings. The conclusions may be expanded to include recommendations which the reviewers feel should be presented to the medical staff for its further action.

2. Recommendations

The UR committee should review each report, discuss it, and formulate concrete recommendations to be appended to the report when it is presented to the medical staff. Unless studies are translated into recommendations designed to improve the policies, practices and procedures of the facility, they are not really accomplishing a useful purpose and constitute a needless expenditure of valuable time. The UR committee should be aware that their ultimate value is in the recommendations for improvements which must flow from their studies. (See Examples E1, E2, and E3.)

3. Follow up

A study made one year may have continuing relevance in subsequent years. Thus, a committee may make a follow-up study to assess the results stemming from their recommendations in an earlier study. See Example D8, where an "audit" committee reviewed cholecystitis and cholelithiasis cases to see if recommendations made two years previously were being followed by the medical staff. (This example of a follow-up study report does not include recommendations for the committee to forward to the medical staff.)

Bibliography

For the past several years various medical societies and medical-based groups have been experimenting with the use of predetermined written criteria for admission, services and lengths of stay on a diagnostic basis, in medical audit or in the "sample" portion of utilization review. The following reference sources discuss this:

"Hospital Utilization Review Manual," Beverly C. Payne, M.D., Editor, University of Michigan Press, Ann Arbor, Michigan, February 1968.

"A Method of Hospital Utilization Review," Sidney Shindell, M.D., LL.B., and Morris London, M.P.H., University of Pittsburgh Press, Pittsburgh, Pennsylvania, 1966.

"Criteria for Effective Utilization Review," Hospital Utilization Project, available from the Project, Pittsburgh, Pennsylvania.

These materials are useful as guides for both surveyor and utilization review committee, since they give specific examples based on experiences of medical groups. (See the criteria and worksheets from the University of Michigan and HUP extracted from their workbooks, for examples of use of predetermined criteria.)

The periodical "PAS Reporter," reports studies from data furnished by PAS-MAP subscribing hospitals on such topics as "Measuring Laboratory and X-ray Utilization," "Cholecystectomy: Preoperative and Total Stay," and "Length of Stay Adjusted for Patient Mix: Friday and Saturday Admissions to Surgery." ("PAS Reporter" is published by the Commission on Professional and Hospital Activities, Ann Arbor, Michigan.) Materials such as this have value in stimulating the undertaking of similar studies which can be adopted by the committee of any size hospital.

The "AMA Kit of Articles on Medical Care Appraisal" is a handy reference collection of reprints of 11 articles, which range in subject from basic explanations of appraisal and techniques to the role of the medical record librarian. It can be obtained from AMA headquarters, Chicago.

A list of other pertinent materials is contained in the bibliography, "Utilization Review; A Selected Bibliography (1933-1969)" prepared at Yale University and distributed by the U.S. Public Health Service.

Part 2

External Organizations Which Provide Assistance to Hospital
Utilization Review Committees

The need for hospitals to collect and analyze patient information has led to the emergence of independent national and regional data processing and analysis organizations in recent years. In certain parts of the country hospitals may now select from several different programs designed to furnish this type of service.

These organizations and their services do not perform utilization review nor replace utilization review committees. They do collate and summarize the raw data sent to them by subscribing hospitals, and from this data periodically perform summary-type and/or rank-order studies sent as reports to subscribing hospitals. They do not draw conclusions related to the operations of the individual hospital. However, the appropriate use of the profiles they prepare can be utilized by the individual utilization review committee to analyze and make recommendations to the medical staff and to administration.

To repeat: merely subscribing to these services and receiving data from them does not satisfy the utilization review requirement. Further action utilizing the data must be taken by the facility's utilization review committee.

NOTE: The Federal government has no connection with and does not endorse any commercial computer service. The firms named in this Appendix and the excerpts from their publications are shown only as examples of available services.

A. Nationwide Organizations

The typical nationwide organization requires its subscribing hospitals to record on abstract forms selected types of patient information from the medical records of discharged patients. Each month these abstract forms are batched and mailed to the central office of the national agency. Periodically, the hospitals receive summaries of their data in the form of computer printouts or reports displaying patient information.

1. PAS-MAP

An example of this type of project is the Professional Activities Study (PAS) and its related Medical Audit Program (MAP) which sends back coded information about patient treatment data and services of the hospital with the patient and his physician identified only by code number. In addition, statistics which hospitals are required to keep (i.e., death listing, autopsy rate, patient days, length of stay, etc.) are included in the periodic reports.

The Commission on Professional and Hospital Activities, the parent organization for the PAS-MAP projects, from time to time publishes a book of tables compiled on a diagnostic basis relative to averaged lengths of stay in short-term general hospitals. (See Example B-2.) Compiled from data submitted by subscribing hospitals, the books of tables can be very useful for comparative purposes. "Length of Stay in Short-Term General Hospitals (1963-1964)" and "Length of Stay in PAS Hospitals, United States Pre- and Post-Medicare" covering the periods January 1965 through June 1966 and January 1967 through June 1968 are obtainable from the Commission on Professional and Hospital Activities, Ann Arbor, Michigan.

Further information regarding PAS-MAP projects can be obtained from the office of the projects: Commission on Professional and Hospital Activities, Ann Arbor, Michigan 48108. Facilities which do not utilize the data analysis service may nevertheless subscribe to its bulletin, the "PAS Reporter," (see Examples B-3 and D-3) which devotes each issue to a report of an overall study based on data from hospitals using the service, general information about the programs, and informational articles concerning utilization review and medical audit.

B. Regional Organizations

Organizations which serve specific regions, local areas or States operate in basically the same manner. Local organizations take advantage of their proximity to work closely with the subscribing hospitals in interpretation of computer reports.

1. HUP

The Hospital Utilization Project, a typical regional data organization, sends back printouts displaying patient information by diagnostic category to each subscribing hospital. In addition, the Project develops comparative reports presented in graphic style (see "Focus," Example D-5) which contain profiles of care for specific diagnoses and compare the experience of subscribing hospitals in treating these diagnoses. Criteria for diagnostic categories developed by panels of Pennsylvania physicians are also available to reviewing physicians through the project. These criteria can be used as guidelines by the reviewing physician in examining patient records. (See Examples A-2 and C-2.) Further information can be obtained from the Hospital Utilization Project, 3530 Forbes Avenue, Pittsburgh, Pennsylvania 15213.

2. BCA

Blue Cross Association has developed several computerized systems, which may be helpful to small hospitals or those wishing to utilize computer printout service. Blue Cross Data Service (BCDS) in Massachusetts and QUEST in Northeastern Ohio are two specialized

systems of BCA. In addition, the program described above under "HUP" is now available on an area basis from BCA.

C. Joint Committees

Another approach to assisting utilization review committees consists of a group of hospitals or professional organizations jointly establishing the most frequent lengths of stay for specific conditions. These lengths of stay are then used by the utilization review committee in establishing meaningful extended duration dates by individual diagnosis, to select cases for review.

1. AID

An example of this type of system is Approval by Individual Diagnosis (AID), co-sponsored by New Jersey Medical Society, New Jersey Hospital Association, and the Blue Cross and Blue Shield Plans for New Jersey. Based on a study of New Jersey hospitals' average length of stay for 308 diagnoses, AID sent this information to each medical staff and requested each to review the report and to recommend a proper length of stay for each diagnosis, which then would constitute the number of initially allowable days beyond which recertification would be required. Except in a few instances, the most frequently given opinion was used as the number of days initially allowable. Note that the AID program is based on average lengths of stay and not on the appropriateness of the length of stay. The AID Manual (see Example B-1) covering these 308 diagnoses, conditions and procedures is now being used by hospital utilization review committees across the country and by Blue Cross. Further information can be obtained from the Hospital Service Plan of New Jersey, 500 Broad Street, Newark, New Jersey 07102.

D. Commercial Computer Services

Various commercial systems and computer-based companies such as Medi-Data (including Computer Systems International and Banneker Systems, Inc.) and Medinet offer basic data summary services which produce printout reports similar to those of PAS-MAP and HUP. These programs are designed primarily for use in hospitals which are large enough to produce their own comparative data but which do not have computer equipment available. The companies will work out special reports needed by the individual facility, or use a standard format to summarize individual case data which must be culled by medical record department personnel using abstract forms. Other systems companies such as Cara Corporation will help a facility to work out reports to serve its requirements and will recommend the computer equipment needed to produce such reports.

Part 3

Use of Forms and Formats to Assist in Utilization Review
in Hospitals

Forms

The utilization review committee's use of special forms can assist physicians in performing review and increase the efficiency of the review process. The forms can be designed to summarize patient information for the reviewer, or to provide a convenient checklist for the reviewing physician to use in listing his comments and decision relative to cases he has reviewed. A variety of forms have been devised to aid physician members of utilization review committee in the review process.

Examples of worksheets and checklists are included in many of the reference works cited in the surveyor's guidelines and in Part 1. Commercial forms are also available. However, it is strongly recommended that a utilization review committee consider all of these as guides and tools, developing forms appropriate for UR at the institution the committee serves.

1. Face sheets (admission - summary sheets) may profitably be employed in UR to identify cases for extended duration review because they usually contain the date of admission and admitting diagnosis. They are used primarily for identification and coding of hospital charts by the medical record department. They generally contain patient identification information and only minimal information such as diagnosis, dates of admissions and discharge, and surgical procedures. Since they contain little substantive information about the condition of the patient, the course of treatment carried out in the hospital, and the prognosis, they therefore should not be used in lieu of the chart or an abstract by the reviewing physician. (See Example C7.)

2. Medical abstracts prepared for the reviewing physician by the medical record department or the nursing staff contain more medical information than face sheets and may be used by reviewing physicians to quickly determine essential information about cases. If the information on the abstract is sufficient as a basis for a medical decision, the physician has saved the time that he would have needed to review the entire chart to gather essential information, since this has already been done for him on the abstract form. However, more information may be necessary on individual cases than can be efficiently recorded on a case abstract. Thus, the option to review the entire chart must always be available to the reviewer.

Abstracts should contain patient identification data and at least the following minimal information: date of admission, admitting diagnosis, results of pertinent laboratory and diagnostic studies, treatment and therapy; and an indication of the patient's condition from the date of admission to the present time. With easy access to this information the reviewing physician often will not have to spend the time necessary to go through the entire chart. (See Examples C3 from HUP and C4 from PAS-MAP.)

3. Physician's checklists and worksheets are used by many review committees to insure that certain information is recorded for the committee's review and by the reviewing physician after he examines individual patient records in either the extended duration or general sample review. These checklists include appropriate patient identification and contain questions about the necessity of hospitalization in extended duration cases which require either the physician's written answer or his checking the appropriate response from a list of alternatives. They may also require the reviewer to list the reasons for continued hospitalization in extended duration review. A variety of additional information may be requested on the checklists or worksheets such as: the appropriateness of treatment and therapy; information about utilization of hospital services, estimated further duration of hospital stay and necessity of re-review. The format of the diagnostic category study examples (C1 and C2) can readily be adjusted for use with other diagnoses, since the study pattern is a basic outline.

In the sample review, checklists or worksheets can be used by medical record department personnel to record the vital information desired by the committee. The information from the individual worksheets is then tabulated and used by the committee. (See Examples C1, 2, 3, 4, and 8.)

Formats

The work of any committee should be reflected in the minutes it keeps of the conduct of the committee's business whenever a meeting is held. The Joint Commission has emphasized that medical staff committees should keep adequate, carefully prepared minutes. Committee minutes should list members attending and those absent; any individual cases discussed, identified by record number, a summary of the discussion, and disposition. The utilization review committee should also report summary data for the long-stay (continuous extended duration) cases reviewed, and status reports on continuing sample or other basis studies and reports of any studies completed during the interval since the last committee meeting. The committee's report together with its recommendations to the medical staff either may have appended

a copy of a special study report or may summarize the findings, and should state definite recommendations for further action to be taken by the medical staff and/or administration. (See Examples E1 and E2.) The report of a special study should cover the number of cases reviewed by category and the major findings, guides or criteria used in evaluation, the disposition of the cases reviewed, and general recommendations based on the findings of the study. (See Examples D6, D7, and E3.) Examples D8 and D9 illustrate comparative studies spanning two or more years.

A committee serving several institutions could choose to do comparative studies of data from all the facilities served, and report its general findings and recommendations in the form of a newsletter or occasional report. Examples of this type of report are the PAS-MAP newsletter, the "PAS Reporter" and the HUP newsletter, "Focus." Although these examples were done on a scale which might surpass the mechanical facilities available to a community utilization review committee, the format of the newsletters would be adaptable for use by a committee serving a group of small institutions, having limited clerical and record staff available to assist with studies. A medical society committee which holds weekly subcommittee work sessions and holds a monthly meeting of the full committee could send a report of the work for the month and its individual facility recommendations to each facility in addition to the weekly report on results of the work sessions. (See Examples D2, 3, 4 and 5.)

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"HOSPITAL UTILIZATION REVIEW MANUAL" - University of Michigan
Medical Center

CRITERIA FOR ACUTE MYOCARDIAL INFARCTION

(I.C.D.A. No. 420.1)

(Cardiology Panel)

Indications for Admission:

1. Diagnosis established
2. Diagnosis suspected

Services Recommended:

1. History: Specific reference to character, onset, radiation, and duration of pain.
Dyspnea, vomiting, sweating, weakness, syncope, leg pains, hemoptysis or dependent edema. Previous history of angina, myocardial infarction, hypertension or diabetes. Cerebrovascular insufficiency or intermittent claudication.
2. Physical Examination: Specific reference to: signs of shock (pallor, apprehension, restlessness, pulse rate, sweating, cyanosis, tachypnea)
Blood pressure (both arms)
 - a. Heart: Size, rhythm and rate, sounds, murmur or friction rub
 - b. Lungs: Type and distribution or rales, friction rub, breath sounds
 - c. Abdomen: Liver edge, spleen size, pulsation of abdominal aorta, femoral pulses
 - d. Carotid artery pulsation or bruit and jugular vein distention
 - e. Calf tenderness and/or edema
3. Laboratory:
 - a. C.B.C.
 - b. Urinalysis
 - c. E.C.G. on admission and prior to discharge
 - d. Serum enzyme studies if E.C.G. not diagnostic
3. Laboratory Consistent with Diagnosis:
 - a. Blood sugar 2 hour p.p.
 - b. Serum enzymes
 - c. Prothrombin or clotting time
 - d. Serum lipids
 - e. Serum electrolytes
4. Roentgenology:
Chest roentgenogram
4. Roentgenology Consistent with Diagnosis:
 - a. Upper gastrointestinal and gallbladder roentgenograms only in establishing the diagnosis—contraindicated in established acute myocardial infarction
 - b. Angiocardiography, aortography when dissecting aneurysm is suspected
5. Special Procedures:
Cardiac monitoring
5. Special Procedures Consistent with Diagnosis:
 - a. Cardioversion
 - b. Pacemaker

Acute Myocardial Infarction (con't)
(Cardiology Panel)

Probable Length of Stay in Uncomplicated Cases:

1. In young individuals, free of other disease, with small infarcts as judged by: E.C.G. and/or enzymes and changes in w.b.c., temperature, and sedimentation rate: 14-21 day
2. In other than small transmural infarction: 21-28 days

Complications that May Extend Length of Stay:

1. Early complications
 - a. Shock
 - b. Coronary pain of unusually long duration
 - c. Cardiac failure
 - d. Serious arrhythmias
 - e. Other heart disease
 - f. Unusually large infarction (by E.C.G. or enzymes)
 - g. Extension of infarction
 - h. Embolism - systemic or pulmonary
 - i. Perforated interventricular septum
 - j. Ruptured chorda tendinea
 - k. Ruptured papillary muscle
2. Late Complications (beyond first week of illness)
 - a. Cardiac failure
 - b. Serious arrhythmias
 - c. Embolism
 - d. Recurrence of coronary pain suggesting impending infarction
 - e. Persistent tachycardia
 - f. Difficulty in regulation of anticoagulant therapy (if prothrombin time profoundly prolonged or inadequately prolonged)
 - g. Pericarditis (treat as early complication)
3. Other Important Disease

- N.B. a. The minimum length of stay of 21 days should begin after control of any or all early complications
- b. Late complications will prolong stay beyond 21 days by the length of time required to control them
 - c. An extension of the original infarction or a second myocardial infarction will require the minimum 21-day period of hospitalization as of their occurrence

Indications for Discharge:

1. Normal or stable pulse and normal temperature
2. Freedom from pain except perhaps occasional mild angina pectoris
3. Ambulant unless transferred to other bed rest facility
4. If all above criteria are met and home facilities for convalescence are adequate, discharge 18 days from completion of infarction may be permitted

Criteria for Cholecystitis and Cholelithiasis
(Surgery Panel)

I. Indications for Admission

- A. Acute abdomen requires hospitalization for evaluation.
 - 1. Nausea, vomiting, dehydration, pain of gall bladder colic
 - 2. History of recurrent pains or gall bladder attacks
 - 3. Fever associated with above symptoms
 - 4. Jaundice
 - 5. Present tenderness and pain in right upper quadrant
 - 6. Leukocytosis
- B. Diagnosis of gall stones or non-functioning gall bladder already established, patient is admitted for cholecystectomy.

II. Hospital Services Required or Consistent with Diagnosis

- A. If no surgery performed (uncomplicated)
 - 1. CBC
 - 2. Urinalysis
 - 3. Chest x-ray
 - 4. Liver function study
 - 5. GI Series and cholecystogram
 - 6. ECG when indicated by history or physical findings
- B. If operated upon, in addition to A above,
 - 1. Operating Room
 - 2. Anaesthesia
- C. With complications, in addition to A and B,
 - 1. Cholangiograms, intravenous therapy, or T-tube drainage
 - 2. Pancreatic function tests
 - 3. Serum amylase
 - 4. Consultation
 - 5. Oxygen therapy
 - 6. Parenteral fluids
 - 7. Antibacterials
 - 8. Steroid therapy
 - 9. Blood transfusion

III. Expected Length of Hospital Stay

- A. With history of recurrent apparent gall bladder attacks, may be admitted for study and operation; up to 5 days pre-operative stay may be required.
- B. In acute attack, operation or decision may be delayed for studies, hydration and subsidence of attack - 7 - 10 days postoperative.
- C. In acute attack, patient may go home on subsidence, so there will be no postoperative length of stay.

Cholecystitis and Cholelithiasis (Continued)
(Surgery Panel)

- D. In cholecystectomy, uncomplicated length of stay is 7 - 10 days postoperative.
- E. If exploration of common duct also required and T-tube left for drainage, 12 to 17 days postoperative stay may be required.
- F. If duodenotomy is done, stay is prolonged and unpredictable.
- G. If cholecystotomy is done, with drainage of gall bladder itself and/or the subhepatic or subphrenic space, stay is unpredictable.
- H. If empyema of gall bladder or associated pancreatitis, operation would follow subsidence. Postoperative stay same as uncomplicated cholecystectomy.

IV. Complications That May Extend Length of Stay

- A. Obstruction of the common duct
- B. Bile peritonitis
- C. Necrosis of wall of gall bladder with or without perforation
- D. Hepatitis
- E. Peritonitis
- F. Wound disruption
- G. Empyema of gall bladder
- H. Associated pancreatitis
- I. Subphrenic abscess
- J. Wound infection
- K. Medical complications
 - 1. Phlebitis
 - 2. Pneumonia
 - 3. Coronary
 - 4. Diabetes, etc.

V. Indications for Discharge

- A. With no surgery
 - 1. Acute phase of pain, tenderness, nausea and vomiting is over
 - 2. Patient is comfortable and afebrile
 - 3. No leukocytosis
 - 4. Return of peristalsis (normal eating and normal defecation)
- B. With cholecystectomy
 - 1. Wound healing satisfactory
 - 2. Patient is comfortable and afebrile
- C. With cholecystotomy
 - 1. Same as cholecystectomy except that the period of drainage will be indefinitely longer and prospect is for further readmission for cholecystectomy

Accepted Criteria for Medical Care of
T&A patients by Medical Audit Utilization
Subcommittee of the Department of Otolaryngology,
as accepted on January 6, 1970

Example A-3

1. Number of patients

2. For history and physical workups of T&A's and other minor surgical cases, that do not require a stay in the hospital longer than forty-eight hours, the old short forms must be used (#722-20). For all other cases, long forms should be used. The history and physical examination must be complete, especially regarding the bleeding tendencies: history of bleeding disorders in family, easy bruising, excessive bleeding from small cuts, or previous surgery, frequent nose bleeds, etc.

3. The progress notes must contain all important facts concerning patient's condition, treatment, etc. from the day of admission until the discharge from the hospital, at least every second day, or more often if necessary.

4. Doctors orders should contain all basic orders concerning the patient's condition, lab work, medicine, diet, etc.

5. a. Lab work must include: Urine, CBC (which includes hemoglobin, and differential count).

b. All adults over 20 years of age, the following must be included: STS, chest X-ray, EKG if indicated.

c. In case of history of bleeding tendencies:

1. bleeding coagulation time
2. partial thromboplastin
3. prothrombin
4. platelets

If test findings are abnormal, consult hematologist.

d. Normal values of blood cells

NORMAL BLOOD CELLS

	<u>Birth</u>	<u>1 year</u>	<u>5 years</u>	<u>10 years</u>
Erythrocytes	4.9-5.5	4.5-5.0	4.7-5.3	4.8
Hemoglobin	16-20	11.5-13	12.5	12.5
Hematocrit	52-60	37-46	36	36
WBC	10-20.000	6-10.000	6-12.000	6-10.000
Neutrophils	45-55%	35-45%	40-50%	45-55%
Lymphocytes	45-30%	60-50%	55-45%	50-45%

6. Preoperative medication
 - a. Drugs used: Nembutal, Demerol, Atropine, or Scopolamine, Morphine, Phenogen.See list enclosed for normal dosage at _____ Hospital
- b. time given prior to surgery: One hour
7. Hemostasis:
 - a. Sutures
 - b. Coagulation Current
 - c. Tannic Acid
 - d. Etc.
8. Operating time
9. Postoperative complications:
 - a. Hemorrhage
 1. with coagulation
 2. with sutures
 3. Tannic acid
 4. without sutures
 - b. Fever (100 or better)
 - c. Other (convulsions, etc.)
10. Postoperative care:
 - a. Antibiotics
 - b. Blood transfusions
11. Other procedures done in addition to T&A
 - a. Myringotomies
 - b. Circumcision
 - c. Others
12. Days in hospital
13. Age of patient

(Example A-3-3)

PEDIATRIC DOSAGE SCHEDULE FOR PREOPERATIVE
MEDICATION BY INTRAMUSCULAR ROUTE (mgm)

<u>WEIGHT IN POUNDS</u>	<u>NEMBUTAL</u>	<u>DEMEROL</u>	<u>MORPHINE</u>	<u>PHENERGAN</u> used \bar{c} equal Demerol	<u>SCOPOLAMINE & ATROPINE</u>
10	15	10	.6	5.0	.1
15	20	10	.8	7.5	.1
20	25	15	1.2	10.0	.1
25	35	15	1.4	12.5	.1
30	40	20	1.6	15.0	.15
35	45	25	1.8	17.5	.15
40	55	25	2.0	20.0	.2
45	60	30	2.4	22.5	.2
50	65	35	2.5	25.0	.2
55	75	35	2.8	27.5	.2
60	80	40	3.0	30.0	.2
65	85	45	3.3	32.5	.3
70	95	45	3.5	35.0	.3
75	100	50	3.8	37.5	.3
80	100	55	4.0	40.0	.3
85	100	55	4.3	42.5	.3
90	100	60	5.0	45.0	.3
95	100	65	5.8	47.5	.4
100	100	65	6.0	50.0	.4

The Permanent Committee on Blue Cross and
Blue Shield of New Jersey, Newark, New Jersey

Code		Medical	Surgical
541	Ulcer of duodenum	14*	16
543	Gastritis and duodenitis	8*	16
545	Other diseases of stomach and duodenum		18
	Appendicitis (550-553)		
550	Acute appendicitis	5	7*
	Hernia of abdominal cavity (560-561)		
560	Hernia of abdominal cavity without mention of obstruction, including inguinal, femoral, umbilical, ventral and epigastric, incisional, and diaphragmatic hernia	10	8*
	Other diseases of intestines and peritoneum (570-578)		
570	Intestinal obstruction without mention of hernia	12	15*
571	Gastro-enteritis and colitis, except ulcerative, age 4 weeks and over	8*	13
572	Chronic enteritis and ulcerative colitis	14*	21
574	Anal fissure and fistula		7
575	Abscess of anal and rectal regions		7
577	Peritoneal Adhesion		13
578	Other diseases of intestines and peritoneum	10	13*
	Diseases of liver, gall bladder, and pancreas (580-587)		
581	Cirrhosis of liver	15	15
583	Other diseases of liver	14	
584	Cholelithiasis	9	14*
585	Cholecystitis and cholangitis without mention of calculi	10*	14
586	Other diseases of gall bladder and biliary ducts	10	14*
587	Diseases of pancreas	14	
X. DISEASES OF THE GENITO-URINARY SYSTEM (Codes 590-637)			
	Nephritis and nephrosis (590-594)		
590	Acute nephritis	15	15
*Signifies number of days approved unless type of treatment, medical or surgical, specified.			

"LENGTH OF STAY IN SHORT-TERM GENERAL HOSPITALS (1963-1964)" Example B-2
Commission on Professional and Hospital Activities,
Ann Arbor, Michigan

Diseases of the Circulatory System

LENGTH OF STAY IN 319 U.S. SHORT TERM GENERAL HOSPITALS
1963-64 PROFESSIONAL ACTIVITY STUDY

DX GROUP 791 ACUTE CORONARY OCCLUSION (ICDA 420.1)

TYPE OF PATIENT (1)	TOTAL PATIENTS* (2)	AVG. STAY (3)	VARI- ANCE (4)PERCENTILES.....						
				5TH (5)	10TH (6)	50TH (7)	75TH (8)	90TH (9)	95TH (10)	99TH (11)
1. SINGLE DX										
A. NOT OPERATED										
0-19 YRS	4	9.3	51	1	1	9	15	17	17	17
20-34	248	20.3	107	4	6	20	27	33	38	47
35-49	4746	21.9	97	5	9	21	28	34	38	49
50-64	9214	22.8	109	6	10	22	29	36	41	52
65+	5725	22.1	120	5	9	21	28	36	42	55
B. OPERATED										
0-19 YRS										
20-34										
35-49	16	18.7	114	2	3	21	26	34	36	36
50-64	27	20.0	175	4	5	17	30	33	48	59
65+	14	28.4	399	2	6	25	34	59	68	68
2. MULTIPLE DX										
A. NOT OPERATED										
0-19 YRS	12	15.8	56	4	4	15	20	25	28	28
20-34	141	19.8	131	2	5	21	27	34	38	51
35-49	2869	22.6	131	5	8	22	29	37	42	58
50-64	8469	23.9	138	6	10	23	30	39	44	62
65+	9057	23.8	157	6	9	22	30	40	46	67
B. OPERATED										
0-19 YRS	2	8.5	41	4	4	8	13	13	13	13
20-34	11	26.3	158	13	14	26	37	39	53	53
35-49	97	28.6	224	10	11	27	37	51	59	99+
50-64	322	29.9	287	7	11	28	41	55	65	99+
65+	333	32.3	281	8	13	30	43	60	67	99+
SUBTOTALS:										
1. SINGLE DX										
A. NOT OP										
B. OPERATED	57	21.7	220	3	5	20	28	36	59	68
2. MULTIPLE DX										
A. NOT OP										
B. OPERATED	765	30.7	277	8	11	28	41	55	66	99+
1. SINGLE DX										
2. MULTIPLE DX										
A. NOT OPERATED	40485	23.0	130	6	9	22	29	37	43	58
B. OPERATED	822	30.1	278	7	11	28	40	55	65	99+
TOTAL										
0-19	18	13.5	59	1	4	14	19	25	28	28
" 20-34	400	20.3	117	3	6	21	27	34	39	51
" 35-49	7728	22.2	111	5	9	21	28	35	40	54
" 50-64	18032	23.4	126	6	10	22	29	38	43	58
" 65+	15129	23.3	148	6	9	22	29	39	45	64
GRAND TOTAL										
	41307	23.1	131	6	9	22	29	37	43	60

* DEATHS ARE EXCLUDED THROUGHOUT. PATIENTS STAYING 100 DAYS OR MORE ARE EXCLUDED FROM COLS. 2-4 BUT INCLUDED IN COMPUTATION OF PERCENTILES.

"LENGTH OF STAY IN PAS HOSPITALS, UNITED STATES,
PRE- AND POST-MEDICARE"
Commission on Professional and Hospital Activities
Ann Arbor, Michigan

(Example B-2-2)

PRE- MEDICARE, 537 Hospitals, January 1965-June 1966

79: Acute coronary occlusion (420.1)

TYPE OF PATIENT (1)	TOTAL PATIENTS (2)	AVG. STAY (3)	VARI- ANCE (4)PERCENTILES.....						
				5TH (5)	10TH (6)	50TH (7)	75TH (8)	90TH (9)	95TH (10)	99TH (11)
1. SINGLE DX										
A. NOT OPERATED										
0-19 YRS	6	14.8	146	4	4	5	23	32	32	32
20-34	271	19.3	94	5	6	20	25	31	36	44
35-49	5044	21.2	90	5	9	21	27	32	37	46
50-64	9937	22.3	98	7	10	21	28	34	39	51
65+	6226	21.9	109	6	9	21	28	35	41	52
B. OPERATED										
0-19 YRS										
20-34	4	22.0	337	3	3	17	21	47	47	47
35-49	26	20.5	204	2	2	19	28	33	43	65
50-64	42	27.3	329	3	3	27	39	61	80	99+
65+	23	22.7	138	4	4	21	31	38	39	42
2. MULTIPLE DX										
A. NOT OPERATED										
0-19 YRS	7	31.6	1133	16	16	32	39	50	50	50
20-34	181	20.8	109	4	7	20	28	32	38	50
35-49	3365	22.6	120	6	9	22	28	36	42	57
50-64	10390	23.7	131	7	10	23	29	37	43	61
65+	10891	23.6	149	6	9	22	30	39	45	68
B. OPERATED										
0-19 YRS	2	3.0	2	2	2	2	4	4	4	4
20-34	6	27.3	412	5	5	18	40	61	61	61
35-49	137	27.9	268	5	11	26	35	47	60	92
50-64	419	30.2	257	8	12	28	39	54	67	99+
65+	470	31.1	242	9	13	29	41	51	60	98
SUBTOTALS:										
1. SINGLE DX										
A. NOT OPERATED	21484	21.9	99	6	9	21	28	34	39	51
B. OPERATED	95	24.1	250	2	3	24	33	45	62	99+
2. MULTIPLE DX										
A. NOT OPERATED	24834	23.5	138	6	9	22	29	38	44	64
B. OPERATED	1034	30.2	254	8	12	28	39	52	62	99+
1. SINGLE DX										
2. MULTIPLE DX	21579	21.9	100	6	9	21	28	34	39	51
	25868	23.8	144	6	10	22	30	39	45	66
A. NOT OPERATED										
B. OPERATED	46318	22.8	121	6	9	22	28	36	42	58
	1129	29.7	256	7	11	28	39	51	62	99+
TOTAL 0-19 YRS										
" 20-34	15	21.1	228	2	4	23	32	39	50	50
" 35-49	462	20.0	105	4	6	20	26	32	38	50
" 50-64	8572	21.9	106	5	9	21	28	34	40	52
" 50-64	20788	23.2	120	7	10	22	29	36	42	59
" 65+	17610	23.2	140	6	9	22	29	38	44	64
GRAND TOTAL										
	47447	22.9	125	6	9	22	28	36	42	60

"LENGTH OF STAY IN PAS HOSPITALS, UNITED STATES,
PRE- AND POST-MEDICARE"
Commission on Professional and Hospital Activities,
Ann Arbor, Michigan

(Example B-2-3)

POST-MEDICARE, 972 Hospitals, January 1967-June 1968

79: Acute coronary occlusion (420.1)

TYPE OF PATIENT (1)	TOTAL PATIENTS (2)	AVG. STAY (3)	VARI- ANCE (4)PERCENTILES.....						
				5TH (5)	10TH (6)	50TH (7)	75TH (8)	90TH (9)	95TH (10)	99TH (11)
1. SINGLE DX										
A. NOT OPERATED										
0-19 YRS	9	11.7	135	1	1	5	24	29	29	29
20-34	503	18.6	78	3	6	20	24	29	32	44
35-49	9819	20.3	77	6	9	20	25	30	35	45
50-64	19654	21.2	83	7	10	21	26	32	37	48
65+	12875	22.1	98	7	11	21	27	34	39	53
B. OPERATED										
0-19 YRS	2	27.0	1250	2	2	2	52	52	52	52
20-34	7	8.6	56	2	2	5	16	19	19	19
35-49	83	18.5	164	2	2	18	27	33	40	60
50-64	150	23.4	200	2	3	23	31	43	47	64
65+	66	28.4	151	9	13	28	36	44	50	59
2. MULTIPLE DX										
A. NOT OPERATED										
0-19 YRS	13	20.2	474	1	2	21	25	29	33	83
20-34	367	19.7	106	3	5	20	25	30	36	54
35-49	7848	21.8	105	6	9	21	27	33	39	55
50-64	22822	22.8	111	7	10	22	28	35	41	57
65+	27045	24.7	152	7	11	23	30	40	48	71
B. OPERATED										
0-19 YRS	2	9.5	85	3	3	3	16	16	16	16
20-34	30	29.0	201	7	13	27	44	47	62	99+
35-49	414	25.3	183	5	9	24	31	42	49	95
50-64	1129	29.5	215	9	14	27	37	50	59	99+
65+	1457	32.8	282	10	15	30	41	57	68	95
SUBTOTALS:										
1. SINGLE DX										
A. NOT OPERATED										
	42860	21.2	86	6	10	21	26	32	37	49
B. OPERATED										
	308	22.8	195	2	3	23	32	43	47	59
2. MULTIPLE DX										
A. NOT OPERATED										
	58095	23.5	131	7	10	22	29	37	44	64
B. OPERATED										
	3032	30.5	249	9	13	28	39	52	64	98
1. SINGLE DX										
	43168	21.2	87	6	10	21	26	32	37	49
2. MULTIPLE DX										
	61127	23.9	139	7	11	22	29	38	45	67
A. NOT OPERATED										
	100955	22.6	113	7	10	21	28	35	41	59
B. OPERATED										
	3340	29.8	249	7	12	27	38	51	62	95
TOTAL										
0-19 YRS	26	16.9	352	1	2	10	25	29	52	83
" 20-34	907	19.3	97	3	6	20	25	30	36	47
" 35-49	18164	21.1	92	6	9	21	26	32	37	50
" 50-64	43755	22.2	103	7	10	21	27	34	40	55
" 65+	41443	24.2	144	7	11	23	29	39	46	68
GRAND TOTAL										
	104295	22.8	119	7	10	22	28	36	42	61

Commission on Professional and Hospital Activities

EXAMPLE B-3

Vol. 7, No. 13 17 November 1969

LENGTH OF STAY FOR MEDICARE PATIENTS, 1969

Patient Group By Diagnosis (1)		H-ICDA Code Range (2)	Length of Stay Percentiles			
			5th (3)	50th (4)	75th (5)	90th (6)
1. Infective (001–136)						
1–1	Intestinal infectious disease	001.0–009.9	2	7	12	19
1–2	Respiratory tuberculosis	011.0–012.9	2	12	22	50
1–3	Nonrespiratory tuberculosis	013.0–019.9	3	11	33	37
1–4	Other bacterial disease	020.0–033.9	3	9	15	40
		035.0–037.0				
		039.0–039.9				
1–5	Streptococcal sore throat	034.0–034.1	2	8	10	20
1–6	Septicemia	038.0–038.9	4	16	28	43
1–7	Enteroviral disease of central nervous system	040.0–046.0	3	10	18	24
1–8	Viral disease with exanthem	050.0–057.9	3	10	17	27
1–9	Other viral disease	060.0–068.9	3	10	15	24
		071.0–074.9				
		076.0–079.9				
1–10	Infectious hepatitis	070.0	5	16	23	32
1–11	Infectious mononucleosis	075.0	9	14	19	19
1–12	Rickettsioses and other anthropol-borne disease	080.0–089.9	3	10	12	16
1–13	Syphilis and other venereal disease	090.0–099.9	2	14	22	40
1–14	Other infective and parasitic disease	100.0–104.9	3	11	17	28
		130.0–136.0				
1–15	Mycoses	110.0–117.9	3	9	15	44
1–16	Helminthiasis	120.0–129.0	6	11	13	18

Notes:

These preliminary data are compiled from the stay experience of 268,468 patients 65 years and over discharged from 1,033 U.S. short-term general PAS hospitals during the period January-April 1969. Patients who died or stayed 100 days or more were excluded.

The diagnosis groupings and code ranges, in parentheses, are the same as those in the Discharge Analysis B report; the subgroups are those in the Length of Stay Package for 1969. For similar groupings for 1967 and 1968 see *Length of Stay in PAS Hospitals, United States, Pre- and Post-Medicare*, published by the Commission on Professional and Hospital Activities, Ann Arbor, Michigan, 1969.

Some of the B report diagnosis groups have been excluded because they comprise maternity patients or infants. (Groups 31 through 35, 39, and 45)

The code ranges are according to the *Hospital Adaptation of ICDA (H-ICDA)*, published by the Commission on Professional and Hospital Activities, Ann Arbor, Michigan, 1968.

The average (mean) number of days of stay ordinarily is between the 50th percentile (median) and the 75th percentile. The meaning of these percentiles can be illustrated by an example. If the 75th percentile for a group of patients is 12 days, it means that 75 percent of the patients stayed 12 days or less.

(Example B-3)

Patient Group By Diagnosis (1)		H-ICDA Code Range (2)	Length of Stay Percentiles			
			5th (3)	50th (4)	75th (5)	90th (6)
2. Malignant Neoplasms (140–209)						
2–17	Malignant neoplasm of mouth, pharynx, and esophagus	140.0–150.9	2	10	21	41
2–18	Malignant neoplasm of stomach	151.0–151.9	3	18	27	38
2–19	Malignant neoplasm of intestine except rectum	152.0–153.9	4	20	30	42
2–20	Malignant neoplasm of rectum	154.0–154.2	3	21	32	46
2–21	Malignant neoplasm of abdominal cavity except intestinal tract	155.0–159.0	4	19	28	39
2–22	Malignant neoplasm of respiratory system except bronchus and lung	160.0–162.0 163.0–163.9	1	8	21	34
2–23	Malignant neoplasm of bronchus and lung	162.1	3	15	24	37
2–24	Malignant neoplasm of bone and connective tissue	170.0–171.9	2	14	25	40
2–25	Malignant neoplasm of skin	172.0–173.9	1	5	10	20
2–26	Malignant neoplasm of breast	174.0–174.2	5	13	19	28
2–27	Malignant neoplasm of cervix uteri	180.0–180.9	3	8	14	30
2–28	Malignant neoplasm of uterus except cervix	181.0–182.9	3	10	16	26
2–29	Malignant neoplasm of female genitalia except uterus	183.0–184.9	3	16	26	39
2–30	Malignant neoplasm of prostate	185	3	13	21	31
2–31	Malignant neoplasm of male genitalia except prostate and scrotum	186.0–187.9	2	16	25	66
2–32	Malignant neoplasm of urinary organs	188.0–189.9	2	10	18	30
2–33	Malignant neoplasm of eye	190.0	2	6	8	15
2–34	Malignant neoplasm of brain	191.0–191.9	4	27	45	66
2–35	Malignant neoplasm of other parts of nervous system	192.0–192.9	2	14	30	38
2–36	Malignant neoplasm of endocrine glands	193.0–194.8	3	11	19	33
2–37	Malignant neoplasm of ill-defined and secondary sites	195.0–199.0	2	13	23	35
2–38	Lymphatic and hemopoietic neoplasms except leukemia	200.0–203.0 208.0–209.0	2	12	23	35
2–39	Leukemia	204.0–207.9	2	10	19	31
3. Other Neoplasms (210–239)						
3–40	Benign neoplasm of buccal cavity, pharynx, and digestive system	210.0–211.9	2	9	16	25
3–41	Benign neoplasm of respiratory system	212.0–212.9	1	4	12	22
3–42	Benign neoplasm of bone, muscle, and connective tissue	213.0–215.0	1	4	9	15
3–43	Benign neoplasm of skin	216.0–216.9 227.0–228.0	1	4	8	14
3–44	Benign neoplasm of breast	217.0	2	3	6	11
3–45	Uterine fibroma	218.0	3	11	16	25
3–46	Benign neoplasm of uterus except fibroma	219.0–219.9	2	4	7	13

(Example B-3)

Patient Group By Diagnosis (1)		H-ICDA Code Range (2)	Length of Stay Percentiles			
			5th (3)	50th (4)	75th (5)	90th (6)
3. Other Neoplasms (210–239) (continued)						
3–47	Benign neoplasm of female genitalia except uterus, vagina, and vulva	220.0–221.0 221.8–221.9	6	13	18	26
3–48	Benign neoplasm of vagina and vulva	221.1–221.2	2	4	5	8
3–49	Benign neoplasm of male genital organs except prostate	222.0–222.9	1	4	5	5
3–50	Benign neoplasm of urinary organs	223.0–223.9	1	5	9	16
3–51	Benign neoplasm of eye	224.0	1	3	6	7
3–52	Benign neoplasm of central nervous system	225.0–225.4	2	16	27	55
3–53	Benign neoplasm of other parts of nervous system	225.5–225.9	2	6	14	24
3–54	Benign neoplasm of endocrine glands except thyroid	226.0–226.4 226.6–226.8	2	15	29	45
3–55	Benign neoplasm (adenoma) of thyroid	226.5	3	6	10	14
3–56	Neoplasm unspecified as to malignancy	230.0–239.9	1	7	14	27
4. Diabetes Mellitus (250)						
4–58	Prediabetes and diabetes mellitus without complication	250.0,250.2, 250.9	3	11	18	27
4–59	Diabetes mellitus with complication	250.1,250.3	4	18	32	53
5. Other Endocrine (240–246; 251–258)						
5–57	Disease of thyroid gland	240.0–246.0	4	10	16	26
5–60	Disease of endocrine glands except thyroid	251.0–258.9	2	9	16	27
6. Nutritional, Metabolic (260–279)						
6–61	Avitaminoses and nutritional deficiency state	260.0–269.9	4	14	24	39
6–62	Metabolic disease	270.0–279.9	2	9	15	26
7. Hematologic (280–289)						
7–63	Iron deficiency anemia	280.0–280.9	3	11	17	24
7–64	Anemia except iron deficiency	281.0–285.9	2	11	18	28
7–65	Disease of hematopoietic system except anemia	286.0–289.0 289.4–289.9	1	11	18	29
7–66	Lymphadenitis except acute	289.1–289.3	2	7	14	16
8. Mental (290–319)						
8–67	Mental retardation	290.0–295.9	1	9	30	99+
8–68	Acute organic brain syndrome	296.1–296.9 298.1–298.9 300.0–300.9 304.0–304.9	2	12	21	35
8–69	Chronic organic brain syndrome	297.0–297.9 299.0–299.9 301.0–301.9 305.0–305.9	2	12	22	40
8–70	Alcoholic psychoses	302.0–303.9	1	6	14	25

(Example B-3)

Patient Group By Diagnosis (1)	H-ICDA Code Range (2)	Length of Stay Percentiles			
		5th (3)	50th (4)	75th (5)	90th (6)
8. Mental (290-319) (continued)					
8-71 Nonorganic psychotic disorders	306.0-309.9	1	19	31	46
8-72 Neuroses	310.0-310.9	2	11	21	34
8-73 Personality and other nonpsychotic mental disorders	311.0-319.9	1	7	11	20
9. Other Nervous System (320-358)					
9-74 Inflammatory disease of central nervous system	320.0-324.0	4	24	35	47
9-75 CNS disease except inflammatory	330.0-349.9	2	12	22	39
9-76 Peripheral nervous system disease	350.0-358.9	2	9	16	27
10. Eye (360-379)					
10-77 Inflammatory disease of eye	360.0-369.9	2	6	11	17
10-78 Other disease of eye	370.0-372.0 377.0-379.1	1	3	7	12
10-79 Strabismus	373.0-373.9	2	4	9	18
10-80 Cataract	374.0-374.9	4	7	9	13
10-81 Glaucoma	375.0-375.9	2	6	9	15
10-82 Detachment of retina	376.0	2	10	13	16
11. Ear (380-389)					
11-83 Other disease of ear	380.0 383.0-385.0 387.0-389.9	2	6	10	16
11-84 Otitis media	381.0-381.9	1	5	9	16
11-85 Otosclerosis	386.0	2	3	4	6
12. Hypertension (400-405)					
12-88 Hypertensive disease	400.0-405.0	3	10	17	26
13. Acute Myocardial Infarction (410)					
13-89 Acute myocardial infarction	410.0-410.9	9	23	30	39
14. Other Heart (390-398; 411-429)					
14-86 Rheumatic fever	390.0-392.9	3	12	21	37
14-87 Chronic rheumatic heart disease	393.0-398.0	3	12	19	29
14-90 Ischemic heart disease except acute myocardial infarction	411.0-414.0	3	11	19	29
14-91 Subacute bacterial endocarditis	421.0-421.9	6	24	40	53
14-92 Heart disease except rheumatic, hypertensive, and ischemic	420.0 422.0-429.9	3	12	19	29
15. CNS Vascular (430-438)					
15-93 Cerebrovascular disease	430.0-438.9	3	14	25	43
16. Vascular (440-458)					
16-94 Arteriosclerosis	440.0-440.9	3	12	21	35
16-95 Aneurysm	441.0-442.0	1	14	22	34
16-96 Other disease of arteries	443.0-443.9 446.0-448.0	2	12	21	35

(Example B-3)

Patient Group By Diagnosis (1)	H-ICDA Code Range (2)	Length of Stay Percentiles			
		5th (3)	50th (4)	75th (5)	90th (6)
16. Vascular (440-458) (continued)					
16-97 Arterial embolism and thrombosis; gangrene	444.0-445.9	4	20	34	52
16-98 Pulmonary embolism	450.0	6	16	26	37
16-99 Phlebitis and thrombophlebitis	451.0-451.9	4	13	19	26
16-100 Other disease of vein and circulatory system	452.0-453.0 456.0-458.9	3	11	17	28
16-101 Varicose veins of leg	454.0-454.9	3	12	24	41
16-102 Hemorrhoids	455.0	3	8	12	17
17. Acute URI (460-465)					
17-103 Acute upper respiratory infection except streptococcal	460.0-465.0	3	8	13	20
18. Pneumonia & Bronchitis (480-491)					
18-105 Pneumonia	480.0-486.0	5	12	19	28
18-106 Acute bronchitis	489.0	3	9	14	20
18-107 Bronchitis, chronic and unspecified	490.0-491.0	3	10	15	23
19. Hypertrophy of T & A (500)					
19-110 Hypertrophy of tonsils and adenoids	500.0	1	4	6	10
20. Other Resp (470; 492-493; 501-519)					
20-104 Influenza	470.0	3	9	15	22
20-108 Emphysema	492.0	3	11	18	29
20-109 Asthma	493.0-493.9	3	10	16	25
20-111 Disease of upper respiratory system except acute URI and tonsils	501.0-508.9	1	3	6	11
20-112 Lung and pleural disease except pneumonia, bronchitis, and emphysema	510.0-519.9	3	11	18	28
21. Dental (520-526)					
21-113 Disease of teeth and jaw	520.0-526.9	1	3	4	9
22. Peptic Ulcer (531-534)					
22-115 Ulcer of stomach and duodenum	531.0-534.3	3	12	19	28
23. Other Upper GI (527-530; 535-537)					
23-114 Disease of mouth and esophagus except dental	527.0-530.9	2	7	13	22
23-116 Gastritis and duodenitis	535.0	2	7	12	19
23-117 Disease of stomach and duodenum except ulcer and inflammation	536.0-537.9	2	9	16	24
24. Appendix (540-543)					
24-118 Acute appendicitis without peritonitis	540.0	5	10	15	21
24-119 Acute appendicitis with peritonitis	540.1	7	16	22	36
24-120 Disease of appendix except acute appendicitis	542.0-543.0	3	7	13	16

(Example B-3)

Patient Group By Diagnosis (1)	H-ICDA Code Range (2)	Length of Stay Percentiles			
		5th (3)	50th (4)	75th (5)	90th (6)
25. Hernia (550–553)					
25–121 Inguinal hernia	550.0–552.0	4	8	11	16
25–122 Hernia of abdominal cavity except inguinal	551.0–551.9 553.0–553.9	3	9	14	22
26. Cholecystitis & Calculus (574–575)					
26–126 Cholelithiasis and cholecystitis	574.0–575.9	4	13	19	27
27. Other GI (560–573; 576–577)					
27–123 Disease of intestine and peritoneum except appendix, hernia, and anal disease	560.0–564.9 567.0–569.9	2	9	15	26
27–124 Anal fissure, fistula, and abscess	565.0–566.0	3	7	11	18
27–125 Disease of liver except infectious and serum hepatitis	570.0–573.9	4	15	24	38
27–127 Disease of gallbladder, biliary ducts, and pancreas	576.0–577.9	3	11	20	31
28. Genitourinary (580–607)					
28–128 Nephritis and nephrosis	580.0–584.0	3	14	23	38
28–129 Infection of kidney	590.0–590.9	3	11	17	29
28–130 Disease of ureter and kidney except nephritis, nephrosis, and calculus	591.0 593.0–593.5	2	10	18	26
28–131 Calculus of kidney and ureter	592.0–592.1	2	8	13	22
28–132 Disease of bladder and urethra except cystitis	594.0–594.9 596.0–599.9	2	8	14	24
28–133 Cystitis	595.0	2	7	13	22
28–134 Disease of prostate including hyperplasia	600.0–602.9	3	12	18	27
28–135 Disease of male genitalia except prostate	603.0–607.9	2	6	10	17
29. Breast (610–611)					
29–136 Disease of breast	610.0–611.9	2	4	7	12
30. Female Genital (612–629)					
30–137 Disease of ovary, fallopian tube, and parametrium	612.0–616.9	3	15	21	33
30–138 Infective disease of uterus, vagina, and vulva	620.0–620.9 622.0–622.1	2	6	11	15
30–139 Disease of female genitalia except infection, prolapse, and menstrual	621.0–621.9 624.0–625.9 627.0–629.9	2	6	11	18
30–140 Uterovaginal prolapse	623.0–623.9	6	11	14	19
30–141 Disorders of menstruation	626.0–626.9	2	4	7	13
36. Skin (680–709)					
36–158 Infection of skin and subcutaneous tissue	680.0–684.0 686.0–686.9	3	11	18	31
36–159 Pilonidal cyst	685	7	8	14	28
36–160 Skin disease except infective and pilonidal cyst	690.0–709.9	2	10	21	36

(Example B-3)

Patient Group By Diagnosis (1)	H-ICDA Code Range (2)	Length of Stay Percentiles			
		5th (3)	50th (4)	75th (5)	90th (6)
37. Musculoskeletal (710-739)					
37-161 Arthritis and rheumatism	710.0-718.0	3	11	19	30
37-162 Somatic dysfunction (osteopathic)	719.0-719.9	4	6	7	25
37-163 Osteomyelitis and other bone disease	720.0-723.9	3	13	23	36
37-164 Internal derangement of other joint	724.0-724.3 724.5-724.9	1	6	10	15
37-165 Internal derangement of knee joint	724.4	4	10	16	21
37-166 Displacement of intervertebral disc	725.0-725.9	3	13	21	32
37-167 Joint disease except internal derangement and intervertebral disc	726.0-729.9	2	11	17	26
37-168 Disease of muscle, tendon, and fascia	730.0-734.9 739.0	2	7	12	22
37-169 Musculoskeletal deformities, except congenital	735.0-738.9	2	7	11	16
38. Congenital (740-759)					
38-170 Congenital anomaly of CNS and head	740.0-745.9	2	6	9	18
38-171 Congenital anomaly of heart and circulatory system	746.0-747.9	3	10	16	31
38-172 Congenital anomaly of respiratory and digestive system	748.0-751.9	2	8	21	28
38-173 Congenital anomaly of genitourinary system	752.0-753.9	1	8	13	24
38-174 Congenital anomaly of musculoskeletal system and generalized congenital anomaly	754.0-759.9	2	8	15	27
40. Symptoms (780-797)					
40-176 Signs, symptoms, and ill-defined conditions	780.0-797.4	2	8	13	22
41. Fractures (800-829)					
41-177 Fracture of skull and face bones	800.0-803.9	1	8	17	31
41-178 Fracture of vertebral column	805.0-806.9	4	15	24	35
41-179 Fracture of thoracic cage, clavicle, or scapula	807.0-807.9 810.0-811.9	2	11	18	28
41-180 Fracture of pelvis	808.0-808.9	5	22	34	48
41-181 Fracture of upper extremity	812.0-817.9	1	7	16	30
41-182 Fracture of upper end of femur	820.0-820.9	8	24	36	56
41-183 Fracture of lower extremity except upper end of femur	821.0-829.0	3	15	27	52
42. Other Trauma (830-959)					
42-184 Dislocation without fracture	830.0-839.9	1	5	12	21
42-185 Sprain and strain	840.0-848.9	2	9	15	25
42-186 Intracranial injury	850.0-854.9	1	8	16	27
42-187 Internal injury of chest, abdomen, and pelvis	860.0-869.9	3	11	21	30
42-188 Laceration, open wound, superficial injury, contusion; foreign body entering through orifice	870.0-939.1	1	7	14	23

(Example B-3)

Patient Group By Diagnosis (1)	H-ICDA Code Range (2)	Length of Stay Percentiles			
		5th (3)	50th (4)	75th (5)	90th (6)
42. Other Trauma (830-959) (continued)					
42-189 Burn	940.0-949.9	2	19	39	62
42-190 Injury to nerve and spinal cord	950.0-959.9	2	21	31	55
43. Adverse Effects (960-999)					
43-191 Adverse effect of medicinal agents	960.0-979.9	1	7	12	20
43-192 Adverse effect of nonmedicinal substances	980.0-989.9	1	5	11	19
43-193 Adverse effect of physical agents and external conditions	990.0-995.9	2	10	18	28
43-194 Complications of surgical procedures	996.0-998.9	2	8	14	25
43-195 Complications of medical care except drugs	999.0-999.9	1	10	21	37
44. Special (Y00-Y17)					
44-196 Special conditions and examinations without sickness	Y00.0-Y02.0 Y04.0-Y10.9 Y13.0-Y13.9	1	2	5	12
44-197 Follow-up medical and surgical care	Y03.0-Y03.9 Y11.0-Y12.9 Y14.0-Y17.9	1	8	19	43

Prepared by
Kenneth W. Teich, MD

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ACUTE MYOCARDIAL INFARCTION WORKSHEET

BASIC DATA

Patient Number	_____	Age	_____
Date of Admission	_____	Sex	_____
Date of Discharge	_____	Payment (check one):	
— For deaths only (check one):		Private	_____
Autopsy	_____	Blue Cross	_____
No autopsy	_____	Commercial	_____
Days of Stay	_____	Insurance	_____
Physician Number	_____	Other (specify)	_____

DIAGNOSES

Primary: Acute myocardial infarction or coronary occlusion (420.1)

Secondary: _____

ADMISSION DATA

	<u>YES</u>	<u>NO</u>
At time of admission diagnosis was:		
established	_____	_____
suspected	_____	_____
Specific reference was made to:		
1. Character of pain?	_____	_____
2. Symptoms or signs of shock?	_____	_____
3. Symptoms or signs of heart failure?	_____	_____
4. Previous history of angina?	_____	_____
5. Previous history of acute myocardial infarction?	_____	_____
6. Previous hypertension?	_____	_____
7. Diabetes?	_____	_____
8. Cerebrovascular insufficiency?	_____	_____
9. Intermittent claudication?	_____	_____
10. Blood pressure finding on admission was	_____ / _____	_____
11. Heart size?	_____	_____
12. Heart rhythm?	_____	_____
13. Heart murmur?	_____	_____
14. Pericardial friction rub?	_____	_____

ACUTE MYOCARDIAL INFARCTION WORKSHEET (con't)

ADMISSION DATA (con't)

	<u>YES</u>	<u>NO</u>
15. Auscultatory lung findings?	_____	_____
16. Size of liver and/or spleen?	_____	_____
17. Abdominal aorta pulsations?	_____	_____
18. Carotid and femoral artery pulsations or bruit?	_____	_____
19. Jugular vein distention?	_____	_____
20. Calf tenderness and/or edema?	_____	_____

HOSPITAL SERVICES

	<u>Done</u>	<u>Not Done</u>
1. C.B.C.	_____	_____
2. Urinalysis	_____	_____
3. E.C.G.	_____	_____
on admission	_____	_____
on discharge	_____	_____
Total number of E.C.G.'s _____	_____	_____
4. Serum enzyme studies	_____	_____
5. Chest roentgenogram	_____	_____
6. Cardiac monitoring	_____	_____

COMPLICATIONS

	<u>YES</u>	<u>NO</u>
Were anticoagulants contraindicated?	_____	_____
If yes, specify reason _____		

Was there an additional infarction?	_____	_____
If yes, on what day of hospital stay did it occur? _____		
Were there other <u>early</u> complications (during first week of illness)?	_____	_____
If yes, 1) Specify complications _____		

2) On what day of hospital stay 1) were early complications controlled?		
Were there other <u>late</u> complications (beyond the first week of illness)?		
If yes, 1) Specify complications _____		

2) How many days were required to control late complications?		

ACUTE MYOCARDIAL INFARCTION WORKSHEET (con't)

DISCHARGE CRITERIA

	<u>YES</u>	<u>NO</u>
1. Pulse and temperature normal?	_____	_____
2. Free of pain?	_____	_____
3. Ambulant?	_____	_____
4. Transferred to bed rest facility?	_____	_____

EVALUATION

Admission was (check one):

Appropriate _____

Inappropriate _____

For appropriate admissions only:

Length of stay: appropriate _____
inappropriate _____

If understay, how many days? _____

If overstay, how many days? _____

Hospital services were (check one):

Adequate _____

Inadequate _____

(Specify) _____

OTHER COMMENTS:

Hospital Utilization Project
Guide for Case Review

(Refer to Criteria)

Hospital _____ Pt. Record No. _____ Age _____ Sex _____
 Accommodation _____ Pay Status _____ Physician No. _____
 Admission Date _____ Day of Week _____ Total Stay _____

I. Condition of Patient on Admission:

Circle each of the following present on admission:

1. Nausea, vomiting, dehydration
2. Abdominal/RUQ pain/tenderness
3. Fever, leukocytosis
4. Jaundice
5. History of recurrent pain or colic
6. History of previous "gallbladder" attacks
7. Previous demonstration of cholelithiasis or non-functioning gallbladder

Was patient admitted as: emergency _____ urgent _____ elective _____

II. Services Received Preoperatively:

Circle each of following if performed in hospital:

CBC urinalysis FBS BUN chest x-ray ECG

Indicate date on which last of above done _____

Indicate date(s)* of: Consultation _____

G.B. series _____ Liver function studies _____

G.I. series _____ Pancreatic " " _____

Other studies (specify) _____

*Note: If any of above done prior to admission, enter "P.T.A." instead of date. If not recorded, enter "N.R."

Indicate any other service performed preoperatively _____

Total preoperative stay _____

(Example C-2)

In light of patient's condition on admission, which of above might have been done as outpatient? (specify) _____

If all of above had been ordered or performed as expeditiously as possible, how many days might preop stay have been shortened? _____

III. Operative Procedure(s): Date _____ Day of Week _____

Circle specific operation(s) performed:

Cholecystectomy - Exploration of common duct

Cholecystotomy - Duodenotomy - T-tube insertion

Other (specify) _____

IV. Complications: Circle if present:

- | | |
|---|--------------------|
| 1. Obstruction of common duct | |
| 2. Bile peritonitis | |
| 3. Necrosis of wall of gallbladder with/without perforation | |
| 4. Empyema of gallbladder | 8. Peritonitis |
| 5. Subphrenic abscess | 9. Wound infection |
| 6. Hepatitis | 10. Phlebitis |
| 7. Pancreatitis | 11. Pneumonia |

Other (specify) _____

V. Discharge: Date _____ Day of Week _____

To what extent was postop stay extended beyond expected 7-10 days for uncomplicated cholecystectomy? _____

If extended, to what extent complications contributed? _____

VI. Evaluation:

What additional information is desired from attending physician before final evaluation? _____

Preop stay: Appropriate _____ Extended _____ No. Days _____

Probable reason for extended stay _____

Postop stay: Appropriate _____ Extended _____ No. Days _____

Probable reason for extended stay _____

Hospital Utilization Project
Guide for Case Review

Hospital COMMUNITY Pt. Record No. CS1509 Age 44 Sex M
 Accommodation SEMI-PRIVATE Pay Status REGULAR
 Admission Date 9/28/64 Day of Week MON Total Stay 16

I. Condition of Patient on Admission:

Circle each of the following present on admission:

1. (Nausea/vomiting), dehydration
2. Abdominal/RUQ pain/tenderness
3. Fever, leukocytosis
4. Jaundice
5. History of recurrent pain or colic
6. History of previous "gallbladder" attacks
7. Previous demonstration of cholelithiasis or non-functioning gall-bladder

Was patient admitted as: emergency ☒ urgent _____ elective _____
 Services Received Preoperatively:

Circle each of following if performed in hospital:

(CBC) (urinalysis) (FBS) (BUN) (chest x-ray) (ECG)

Indicate date on which last of above done 9/30/64Indicate date(s)* of: Consultation 10/1 + 10/6G.B. series 10/5/64 Liver function studies 10/6/64G.I. series 10/2/64 Pancreatic " " _____

Other studies (specify) _____

*Note: If any of above done prior to admission, enter "P.T.A." instead of date. If not recorded, enter "N.R."

Indicate any other service performed preoperatively _____

_____ PARENTERAL FLUIDS _____

Total preoperative stay 10 DAYS

In light of patient's condition on admission, which of above might have been done as outpatient? (specify) NONE - PATIENT

ACUTELY ILL

If all of above had been ordered or performed as expeditiously as possible, how many days might pre-op stay have been shortened? 3-5 DAYS

III. Operative Procedure(s):

Date 10/8/64 Day of Week THURS

Circle specific operation(s) performed:

(Cholecystectomy) - Exploration of common duct

(Cholecystostomy) - Duodenotomy - T-tube insertion

Other (specify) _____

Complications: Circle if present:

1. Obstruction of common duct
2. Bile peritonitis
3. Necrosis of wall of gallbladder with/without perforation
4. Empyema of gallbladder
5. Subphrenic abscess
6. Hepatitis
7. Pancreatitis
8. Peritonitis
9. Wound infection
10. Phlebitis
11. Pneumonia

Other (specify) NONE

Discharge: Date 10/14/64 Day of Week WED

To what extent was post-op stay extended beyond expected 7-10 days for uncomplicated cholecystectomy? NONE

If extended, to what extent complications contributed? _____

Evaluation:

What additional information is desired from attending physician before final evaluation? WHY 10 DAYS IN WORKUP?

WHY 4. I. SERIES BEFORE G.B. SERIES?

Pre-op stay: Appropriate _____ Extended ☒ No. Days 3-5 DAYS

Probable reason for extended stay DELAY IN X-RAY STUDIES

Post-op stay: Appropriate ☒ Extended _____ No. Days _____

Probable reason for extended stay _____

(Example C-2)

Example of Completed HUP Form, "A Method of Hospital Utilization Review," Sidney Shindell, M.D., LL.B., and Morris London, M.P.H.

1 HOSP. CODE

ABSTRACT OF MEDICAL RECORD

2 PATIENT MED. REC. NO.

Hospital Utilization Project

Example 3-31

PART I - IDENTIFYING AND DIAGNOSTIC DATA

3 ADMISSION DATE		MO	DAY	YR	7 HOUR OF ADMISSION 01 - 24 (ADD 12 FOR PM)	
4 CLASS OF ADM.		1. EMERGENCY 3. ELECTIVE 2. URGENT 4. OTHER			8 SERVICE	
5 SEX					9 AGE 01 - 99 NB - NEWBORN 00 - UNDER 1 YR.	
6 MARITAL STATUS		1. SINGLE 3. WIDOW 2. MARRIED 4. DIV. OR SEP.			10 SPECIAL (E.G. RESIDENCE)	
11 ATTENDING PHYSICIAN RESPONSIBLE FOR CASE						
12 OTHER PHYSICIAN OR SURGEON						
13 NUMBER OF CONSULTATIONS						
14 PRIMARY DIAGNOSIS RESPONSIBLE FOR HOSPITALIZATION						
15 OTHER DIAGNOSES AND/OR COMPLICATIONS						
A					E	
B					F	
C					G	
D						
16 DISCHARGE DATE		MO	DAY	YR	17 ACCOMMODATION AT DISCHARGE 1. PRIVATE 3. WARD 2. SEMI-PRIV. 4. NURSERY	
18 DISCHARGE STATUS		2. LEFT AGAINST ADVICE 3. TRANSFERRED 4. EXPIRED-NOT AUTOPSIED			5. EXPIRED - AUTOPSIED 6. CORONERS CASE - NO AUTOPSY 7. CORONERS CASE - AUTOPSIED	
19 PAYMENT STATUS		1. SELF PAY 3. COMMERCIAL 5. FREE 7. U M W 9. MEDICARE 2. BLUE CROSS 4. GOVERNMENTAL 6. WORKER'S COMP. 8. OTHER				

PART II - SURGICAL OR OBSTETRICAL DATA

20 FOR OBSTETRICAL CASES ONLY: 1. LIVE BIRTH 2. STILL BIRTH 3. ABORTED FETUS						
21 PRINCIPAL SURGICAL PROCEDURE: (SEE NOTE BELOW)						
<p>NOTE: DO NOT CODE ANY OF FOLLOWING AS PRINCIPAL SURGICAL PROCEDURE UNLESS NO OTHER SURGERY HAS BEEN PERFORMED.</p> <p>DILATATION AND CURETTAGE CYSTOSCOPY BIOPSY NOT INCIDENTAL TO TISSUE REMOVAL PROCTOSIGMOIDOSCOPY RADIOGRAPHIC PROCEDURES OTHER ENDOSCOPIES</p> <p>IF ANY OF ABOVE PROCEDURES ARE DESIRED IN INDEX, ENTER CODE BELOW</p>						
22 OTHER PROCEDURES:						
A					D	
B					E	
C						
23 DATE OF PRINCIPAL SURGERY		MO	DAY	YR	24 SURGEON	

CONTROL NUMBER

MOTHER/BABY CASE NO.

COMPLETED BY

HUP-1 (R2-67)

① HOSP. CODE

--	--	--

HOSPITAL UTILIZATION PROJECT

② PAT. MED. REC. NO.

ABSTRACT OF MEDICAL RECORD (Example C-3)

③ ADM. DATE

MO.	DAY	YR.

④ HR. OF ADM. (01-24)

--

⑤ CLASS OF ADMISSION

1. EMERGENCY 3. ELECTIVE
2. URGENT 4. OTHER

⑥ AGE (00-99)

--

⑦ AGE CLASS

1. MONTHS
2. YEARS
3. NEW BORN

⑧ SEX AND RACE

1. WHITE MALE 3. NEGRO MALE 5. OTHER MALE
2. WHITE FEMALE 4. NEGRO FEMALE 6. OTHER FEMALE

⑨ SOURCE OF REFERRAL

1. EMERG. RM. 3. PRIV. PHYS. 5. E.C.F. 7. PSYCH. FACILITY
2. O.P.D. 4. OTHER HOSP. 6. REHAB. CTR. 8. OTHER

⑩ DISCH. DATE

MO.	DAY	YR.

⑪ DISCHARGE STATUS

1. ALIVE (ROUTINE) 3. TRANSFERRED 5. EXPIRED (AUT.) 7. COR. CASE (AUT.)
2. LEFT AGAINST ADVICE 4. EXPIRED (NO. AUT.) 6. COR. CASE (NO. AUT.)

⑫ DISCH. DESTINATION

1. OTHER HOSP. 3. HOME CARE PROGRAM 5. PSYCH. FACILITY 7. OTHER
2. E.C.F. 4. REHAB. CTR. 6. NURS. HOME

⑬ PAYMENT STATUS

1. SELF PAY 3. COMM. 5. FREE 7. U.M.W. 9. MEDICARE
2. BLUE CROSS 4. GOV. 6. WK. COMP. 8. MEDICAID 0. OTHER

⑭ NO. OF CONS.

1-9

⑮ PHYSICIAN REND. CONS.

1ST			
2ND			
3RD			

⑯ SERV. PROV. CONS.

1ST	
2ND	
3RD	

⑰ SERVICE

PRIM.	
2ND	
3RD	

⑱ DAYS IN SERVICE

PRIM.	
2ND	
3RD	

⑳ SPECIAL UNITS
CODE DAYS

1ST	
2ND	

㉑ ATT. PHYSICIAN
RESP. FOR CASE

--

㉒ POST-OPERATIVE
DEATH

- 1-YES
2-NO

㉓ TIME OF DEATH

- 1-LESS THAN
48 HRS.
2-EQUAL/GREATER
THAN 48 HRS.

㉔ ACCOMMODATION
AT DISCHARGE

1. PRIVATE
2. SEMI-PRIV.
3. WARD
4. NURSERY

P2

㉕ PRIMARY DIAGNOSIS RESPONSIBLE FOR HOSPITALIZATION

--	--	--	--

㉖ OTHER DIAGNOSIS

A			
---	--	--	--

B			
---	--	--	--

C			
---	--	--	--

D			
---	--	--	--

E			
---	--	--	--

F			
---	--	--	--

G			
---	--	--	--

㉗ PRINCIPAL SURGICAL PROCEDURE

--	--	--	--

㉘ OTHER SURGICAL PROCEDURES

A			
---	--	--	--

B			
---	--	--	--

C			
---	--	--	--

D			
---	--	--	--

E			
---	--	--	--

㉙ SURGEON

--	--	--	--

㉚ OTHER PHYS. OR SURGEON

--	--	--	--

㉛ DATE OF PRINCIPAL SURGERY

MO.	DAY	YR.

㉜ SPECIAL REPORTS - OPTIONAL INPUT

--	--	--	--	--	--

CONTROL NUMBER

USE DARK PENCIL ONLY

PAS 1970 MAP

CASE ABSTRACT

Doctor _____

DISCHARGE DATE		Example C-4	
Day	Month	Year	
		1970	
Batch		Page	

PATIENT NUMBER			

Patient _____

1 PATIENT NUMBER	3 AGE ON ADMISSION 0 <input type="radio"/> Newborn/Stillborn 1 <input type="radio"/> Days (thru 27) 2 <input type="radio"/> Months (thru 23) Age 5 <input type="radio"/> 100 Years + 4 <input type="radio"/> Years	4 SEX 1 <input type="radio"/> Male 2 <input type="radio"/> Female	5 ADMISSION DATE Day Month Year	6 DISCHARGE DATE Day Month Year	7 PAS HOSPITAL NUMBER
---------------------	--	--	---------------------------------------	---------------------------------------	--------------------------

8 DISCHARGE STATUS a DISCHARGED ALIVE 0 <input type="radio"/> With approval 1 <input type="radio"/> Against advice 2 <input type="radio"/> Other hospital 3 <input type="radio"/> Extended care facility 4 <input type="radio"/> Home care program b DIED (includes stillborn) 5 <input type="radio"/> Autopsy 6 <input type="radio"/> No autopsy c TRANSFERRED TO: 7 <input type="radio"/> In OR 8 <input type="radio"/> Postoperative 9 <input type="radio"/> Coroner's case	9 RACE 0 <input type="radio"/> White 1 <input type="radio"/> Nonwhite 2 <input type="radio"/> Black 3 <input type="radio"/> Asiatic 4 <input type="radio"/> Special A	10a EXPECTED PAYMENT 0 <input type="radio"/> Workmen's Comp. 1 <input type="radio"/> Medicaid 2 <input type="radio"/> Govt. agencies (not Medicare, Medicaid or Provincial) 3 <input type="radio"/> Blue Cross 4 <input type="radio"/> Commercial insurance 5 <input type="radio"/> Voluntary charities 6 <input type="radio"/> Special B 7 <input type="radio"/> Private	10b 0 <input type="radio"/> Medicare/Provincial 11 ADMISSION 1 <input type="radio"/> Emergency 2 <input type="radio"/> Urgent 3 <input type="radio"/> From other hospital 12 COMPLICATIONS 4 <input type="radio"/> Hospital infection 5 <input type="radio"/> Other hospital complication	13 HOSPITAL SERVICE a <input type="checkbox"/> b <input type="checkbox"/> Teaching service c <input type="checkbox"/> Interservice transfer	14 CONSULTATIONS GIVEN BY: 0 <input type="radio"/> Same service 1 <input type="radio"/> Medicine 2 <input type="radio"/> Surgery 3 <input type="radio"/> OB-Gyn 4 <input type="radio"/> Pediatrics 5 <input type="radio"/> Psychiatry 6 <input type="radio"/> Physical Medicine
--	---	--	---	---	---

15 OPTIONAL a <input type="checkbox"/> b <input type="checkbox"/> c <input type="checkbox"/>	18 BIRTH WEIGHT lbs or kg <input type="text"/> oz or gm <input type="text"/> 19 WEIGHT lbs or kg <input type="text"/> 20 HEIGHT inches or cm <input type="text"/>	21 TIME OF EARLIEST SURGERY (TIME OF DELIVERY if before earliest surgery) a If begun within 6 hours of admission, mark here <input type="checkbox"/> b If after 6 hours, show day (0=day of admission, 1=next day, etc.) <input type="text"/>	22 ANESTHESIA OF (OR DELIVERY) 0 <input type="radio"/> None 1 <input type="radio"/> Inhalation 2 <input type="radio"/> Intravenous 3 <input type="radio"/> Spinal 4 <input type="radio"/> Saddle block 5 <input type="radio"/> Epidural, caudal 6 <input type="radio"/> Nerve or field block 7 <input type="radio"/> Local 8 <input type="radio"/> Other	23 TISSUE OF 25 PATH REPORT IN CHART 1 <input type="radio"/> Diseased A 2 <input type="radio"/> Diseased B 3 <input type="radio"/> No disease 4 <input type="radio"/> Not coded NO PATHOLOGY REPORT 5 <input type="radio"/> Tissue removed, no report 6 <input type="radio"/> None removed
--	---	--	--	---

Use DARK pencil only. Write legibly. Make marks as illustrated in Manual.

INVESTIGATION				MANAGEMENT				
29 HEMOGLOBIN OR HEMATOCRIT Enter ADMISSION hemoglobin in gm/100 ml Enter whole numbers only—drop tenths	31 URINALYSIS 0 <input type="radio"/> Adm. done 1 <input type="radio"/> Adm. sugar+ 2 <input type="radio"/> Adm. albumin+ 3 <input type="radio"/> Repeat; or routine done later 4 <input type="radio"/> Bile, urobilinogen 5 <input type="radio"/> Hormones 6 <input type="radio"/> Calcium, other minerals	33 EXAMS 0 <input type="radio"/> Rectal 1 <input type="radio"/> Pelvic 2 <input type="radio"/> Funduscopic 3 <input type="radio"/> Tonometry 34 FUNCTION 4 <input type="radio"/> EKG 5 <input type="radio"/> Repeat EKG 6 <input type="radio"/> Thyroid 7 <input type="radio"/> EEG 8 <input type="radio"/> Kidney 9 <input type="radio"/> Pulmonary	35 HEMATOLOGY 0 <input type="radio"/> Hemoglobin 1 <input type="radio"/> White cells 2 <input type="radio"/> Differential 3 <input type="radio"/> Red cells, indices 4 <input type="radio"/> Hematocrit 5 <input type="radio"/> Sedimentation rate 6 <input type="radio"/> Coagulation tests, platelets 7 <input type="radio"/> Prothrombin time 8 <input type="radio"/> Reticulocytes, nucleated RBCs 9 <input type="radio"/> RBC abnormality tests	36 BLOOD Number of units (Record more than 9 units as 9) Whole blood: <input type="checkbox"/> Packed red cells: <input type="checkbox"/>	37 DRUGS A 0 <input type="radio"/> Oral antidiabetics 1 <input type="radio"/> Insulin 2 <input type="radio"/> Thyroid; antithyroid 3 <input type="radio"/> Steroid hormones 4 <input type="radio"/> Diuretics 5 <input type="radio"/> Antihypertensives (hypotensives) 6 <input type="radio"/> Vasopressors 7 <input type="radio"/> Vasodilators 8 <input type="radio"/> Cardiac regulators 9 <input type="radio"/> Anticoagulants	38 DRUGS B 0 <input type="radio"/> Sulfa 1 <input type="radio"/> Antibiotics 2 <input type="radio"/> Other anti-infectives 3 <input type="radio"/> Tranquilizers 39 CARE UNITS 4 <input type="radio"/> Intensive care 5 <input type="radio"/> Cardiac care 6 <input type="radio"/> Special C 7 <input type="radio"/> Special D 8 <input type="radio"/> Special E 9 <input type="radio"/> Special F	40 OTHER THERAPY 0 <input type="radio"/> Parenteral fluids 1 <input type="radio"/> Plasma, blood derivatives 2 <input type="radio"/> Rh immune globulin 3 <input type="radio"/> Isolation 4 <input type="radio"/> Hypothermia 5 <input type="radio"/> Monitoring device 6 <input type="radio"/> Oxygen 7 <input type="radio"/> IPPB 8 <input type="radio"/> Other inhalation therapy 9 <input type="radio"/> Special G	41 RESEARCH A 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/>
42 BLOOD PRESSURE Mark both systolic & diastolic ADMISSION readings 0 <input type="radio"/> 220 or more 1 <input type="radio"/> 190-219 2 <input type="radio"/> 160-189 3 <input type="radio"/> 140-159 4 <input type="radio"/> 120-139 5 <input type="radio"/> 100-119 6 <input type="radio"/> 90-99 7 <input type="radio"/> 80-89 8 <input type="radio"/> 50-79 9 <input type="radio"/> 49 or less	43 TEMPERATURE Mark both ADMISSION and PEAK 0 <input type="radio"/> No admission temp. recorded 1 <input type="radio"/> 38.9 F or less (under 37.0 C) 2 <input type="radio"/> 99 (37.0 - .4) 3 <input type="radio"/> 100 (37.5 - .9) 4 <input type="radio"/> 101 (38.0 - .4) 5 <input type="radio"/> 102 (38.5 - .9) 6 <input type="radio"/> 103 (39.0 - .4) 7 <input type="radio"/> 104 (39.5 - .9) 8 <input type="radio"/> 105+ (40.0+)	44 X-RAY 0 <input type="radio"/> Routine (survey) chest 1 <input type="radio"/> Diagnostic chest, respiratory 2 <input type="radio"/> Digestive tract (including GB) 3 <input type="radio"/> Skeletal 4 <input type="radio"/> Urogenital 5 <input type="radio"/> Pleural and peritoneal cavities NOS 6 <input type="radio"/> CNS and CNS spaces 7 <input type="radio"/> Cardiovascular 8 <input type="radio"/> External soft tissue	45 BLOOD CHEMISTRY 46 DONE 0 <input type="radio"/> Nitrogen derivatives 1 <input type="radio"/> Electrolytes, pH 2 <input type="radio"/> Liver function 3 <input type="radio"/> Transaminase, LDH 4 <input type="radio"/> Proteins, electrophoresis 5 <input type="radio"/> Cholesterol, lipids 47 ABNORMAL RESULT 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 48 BLOOD SUGAR 6 <input type="radio"/> Fasting, random 7 <input type="radio"/> 2-hour postprandial 8 <input type="radio"/> ≥ 150 mg % found in either of above 9 <input type="radio"/> Glucose tolerance 49 ABNORMAL REPEATED 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/>	50 OTHER MICROBIOLOGY 6 <input type="radio"/> Throat or nose 7 <input type="radio"/> Urine 8 <input type="radio"/> Blood 9 <input type="radio"/> Other	51 GASTRIC-STOOL 0 <input type="radio"/> Stool for blood 1 <input type="radio"/> Stool analysis 2 <input type="radio"/> Gastric analysis 52 SEROLOGY 3 <input type="radio"/> Special human antibodies 4 <input type="radio"/> Bacterial antibodies 5 <input type="radio"/> Rheumatoid factors 6 <input type="radio"/> Heterophil 7 <input type="radio"/> C-reactive protein 8 <input type="radio"/> Viral antibodies	53 HISTOLOGY 0 <input type="radio"/> Cervical Pap 1 <input type="radio"/> Other Pap 2 <input type="radio"/> Cell block 3 <input type="radio"/> Frozen section 54 OTHER TESTS 4 <input type="radio"/> Amylase, lipase, absorption tests 5 <input type="radio"/> Serum iron 6 <input type="radio"/> Skin tests 7 <input type="radio"/> Toxicology 55 REFERENCE 8 <input type="radio"/> Selected case 9 <input type="radio"/>	56 RESEARCH B 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/>	

OPTIONAL (by arrangement; e.g. origin, charges, consultants, SSN, drug dosage, ICU days, lab values, etc.)

FOR CPHA USE

57 a	58 a	59 a	60 a	61 a	62 a	63 a

MONTHLY DIAGNOSTIC LISTING, Commission on
Professional and Hospital Activities,
Ann Arbor, Michigan

Example C-5

DIAGNOSES & OPERATIONS										OPER DATA		PATIENT		BASIC		DATA		INVESTIGATION										MANAGEMENT																																																																									
(For Full Explanation See Reverse Side of Form)										ANESTHESIA		STAY		ORIGIN		DISCHARGE		NOT OVERNIGHT		COMPLAINT		PAIN		RESERVED		PATIENT NUMBER		DATA		ADMISSION										CHEMISTRY										OTHER TESTS										SPECIFIC										PACKAGED										DRUGS										MANAGEMENT											
OTHER DIAGNOSES AND OPERATIONS										PHYS SURG		CONSULTATION		AGE		STATUS		HOSPITAL		STAY		COMPLAINT		PAIN		RESERVED		PATIENT NUMBER		DATA		ADMISSION										CHEMISTRY										OTHER TESTS										SPECIFIC										PACKAGED										DRUGS										MANAGEMENT									
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Each line on this form presents one patient's case abstract. Reports using this form, together with the sequence of patients for each, are listed in the tables below.

[illegible]

SERVICE	HOSPITAL DAYS										HOSP #									
	AGE ANALYSIS										DISCHARGE STATUS									
	0 - 13 YRS.					14 - 64 YRS.					DEATHS					PAYMENT STATUS				
	PAT.	STAY	AVG.	DAYS	PAT.	DAYS	PAT.	DAYS	PAT.	DAYS	EXP. NO.	EXP. NO.	EXP. NO.	EXP. NO.	EXP. NO.	SELF-PAY	BLUE CROSS	MEDICAID	MEDICARE	DAYS
MEDICINE	708	10	343	19	365	6	6	6	6	6	1	1	1	1	1	3	13	22	24	19
CARDIOLOGY	30	434	14	10	147	20	287	1	4	5	5	5	5	5	5	2	37	3	46	19
NEOPLASTIC	7	94	13	4	32	3	62	4	4	4	4	4	4	4	4	10	44	11	58	3
OB-LIVE BIR	42	220	5	3	220	9	3	3	3	3	3	3	3	3	3	1	3	1	3	62
OB-STILLBIR	3	9	3	3	3	3	3	3	3	3	3	3	3	3	3	1	3	1	3	3
OB-POT DELIV	12	35	3	12	35	3	3	3	3	3	3	3	3	3	3	1	3	1	3	3
OB-ABOR FETUS	2	8	2	2	8	2	2	2	2	2	2	2	2	2	2	1	4	1	4	4
GYNECOLOGY	6	76	10	43	235	76	1	1	1	1	1	1	1	1	1	1	16	2	13	3
NEWBORN	43	235	5	26	1	5	1	1	1	1	1	1	1	1	1	9	39	11	81	1
PED-RED	27	3	2	3	2	3	2	2	2	2	2	2	2	2	2	12	10	33	6	21
PED-SURG	10	35	4	10	35	7	1	1	1	1	1	1	1	1	1	1	1	2	13	3
PED-FRAC	5	24	5	5	24	4	4	4	4	4	4	4	4	4	4	3	29	9	42	10
SURGERY	37	513	13	1	275	11	237	39	1	10	10	10	10	10	10	3	29	9	42	10
FRACTURES	15	160	11	10	130	5	30	11	2	3	3	3	3	3	3	2	6	6	1	5
ORTHOPEDICS	12	200	23	17	134	3	140	11	1	1	1	1	1	1	1	2	25	4	28	1
TRAUM SURG	25	150	6	22	100	7	69	14	1	1	1	1	1	1	1	3	7	5	15	3
UROLOGY	2	178	6	5	12	5	5	5	5	5	5	5	5	5	5	3	7	11	65	1
DENTAL	5	12	2	16	33	11	11	16	4	4	4	4	4	4	4	1	1	1	2	4
ADULT T + A	4	11	3	2	33	11	11	16	4	4	4	4	4	4	4	1	1	1	2	4
PED T + A	16	33	2	16	33	11	11	16	4	4	4	4	4	4	4	1	1	1	2	4
TOTALS	404	3313	101	419	227	1618	76	1276	218	70	381	9	2	2	2	42	242	111	366	74
																				1257

TOTAL CASES	TRANSFERRED TO										LENGTH OF STAY DISTRIBUTION									
	E C F					HOME CARE					1 TO 3					4-14				
	UNDER 64					UNDER 64					1 TO 3					4-14				
	OTHER	WST.	STAY	AVG.	DAYS	OTHER	WST.	STAY	AVG.	DAYS	OTHER	WST.	STAY	AVG.	DAYS	OTHER	WST.	STAY	AVG.	DAYS
404	3	3	3	3	3	32	57	07	04	03	02	18	18	1	1	3	131	109	617	2
																				84

Example

EXAMPLE 4-7
UNIT NO.

RECORD ROOM

DATE NAME	TIME	ROOM	P	SP	SERV.	RACE	RATE		
MAIDEN NAME			ADDRESS AND ZONE			TELEPHONE			
AGE	DATE OF BIRTH	CIVIL STATUS	RELIGION	NATIVITY	YEARS IN CITY	PREVIOUS ADMISSIONS			
DIAGNOSIS (OR CODE)						DAYS	REVIEW DATE		
PROPOSED OPERATION (OR CODE)									
PRIVATE PATIENT OF			(PEDIATRICIAN)			ON SERVICE OF			
DR.			DR.						
DEPARTMENTAL CODE NO.			OPERATION			DATE OF OPERATION		DAY	
SURGEON			DATE OF DISCHARGE			DAY			
TRANSFER TO			DATE			DAY			
SERVICE									
DISCHARGE DIAGNOSIS						DEPARTMENTAL CODE			
DATE OF IN-HOUSE REVIEW						DATE OF DISCHARGE REVIEW			

TO BE COMPLETED BY REVIEWING PHYSICIAN		(Please check appropriate column)			
ADMISSION DIAGNOSIS:					
A. PRIMARY		REVIEW DATE:	/ /	/ /	/ /
		M.D. REVIEWING:			
B. SECONDARY					
IS ADMISSION FOR DIAGNOSTIC PURPOSES?					
IS ADMISSION FOR TREATMENT?					
DAYS IN HOSPITAL AT TIME OF REVIEW					
HAS ADMISSION DIAGNOSIS CHANGED?					
IF YES, SPECIFY (USE BACK OF SHEET IF NECESSARY)					
IS LENGTH OF STAY JUSTIFIED TO DATE?					
CHART SHOULD BE RE-EVALUATED IN _____ DAYS					
IS PATIENT TRANSFERRED TO MEDICINE?					
SHOULD PATIENT BE TRANSFERRED TO ANOTHER SERVICE?					
SHOULD PATIENT BE READY FOR DISCHARGE WITHIN 48 HOURS?					

MEDICINE

Admitted as:	Admission Diagnosis	Discharge Diagnosis
a) emergency	Primary	Primary
	Secondary	Secondary

1. Days in Hospital _____ || 13. Were progress notes of adequate quality and frequency? _____
2. Transferred from _____ Service. || By Attending? _____
3. Transferred to _____ Service. || _____
4. Does this admission appear to be for diagnosis only? _____ || By House Officer? _____
5. Could services have been provided on an ambulatory basis? _____ || _____
6. Diagnostic Studies: || 14. Could patient's stay have been shortened by transfer to nursing home, convalescent home or chronic disease facility? _____
- a) Have all relevant diagnostic studies been done prior to admission? _____ ||
- b) Have studies been ordered as soon as possible after admission? _____ || 15. Could patient's stay have been shortened by use of visiting nurse, homemaker or home care service? _____
- c) Have studies been provided as soon as possible after ordered? _____ || 16. Did patient remain in hospital unnecessarily long because of prepaid insurance coverage or welfare? _____
- d) Have they been reported promptly? _____ || 17. Was diagnosis adequately justified? _____
7. Have diagnostic studies been ordered _____ || Yes or No? _____ Explain: _____
8. Have not enough diagnostic studies been _____ || _____
9. Have consultations been ordered promptly when required? _____ || _____
10. Have consultations been rendered promptly when ordered? _____ || 18. Was treatment rationally applied? _____
11. Was period between admission and surgery prolonged? _____ || Yes or No? _____ Explain: _____
12. Was hospital stay prolonged because of family or social factors? _____ || _____
- || 19. Was length of stay deviant from usual for this diagnosis? _____ If shorter, was it justified? _____
- || It longer, was it justified? _____

SINAI HOSPITAL of BALTIMORE, INC.
ADMISSION RECORD

ELECTIVE URGENT EMERGENCY (EXAMPLE, C-78) UNIT NO.

DATE	TIME	ROOM	P	SP	SERV.	RACE	RATE	
NAME			MAIDEN NAME			ADDRESS AND ZONE		TELEPHONE
AGE	DATE OF BIRTH	CIVIL STATUS	RELIGION	NATIVITY	YEARS IN CITY	PREVIOUS ADMISSIONS		
DIAGNOSIS (OR CODE)						DAYS	REVIEW DATE	
PROPOSED OPERATION (OR CODE)								
PRIVATE PATIENT OF			(PEDIATRICIAN)			ON SERVICE OF		
DR.	DEPARTMENTAL CODE NO.				OPERATION	DR.	DATE OF OPERATION	DAY
SURGEON						DATE OF DISCHARGE		DAY
TRANSFER TO						DATE	DAY	
DISCHARGE DIAGNOSIS						SERVICE		
						DEPARTMENTAL CODE		
DATE OF IN-HOUSE REVIEW						DATE OF DISCHARGE REVIEW		

TO BE COMPLETED BY REVIEWING PHYSICIAN	(Please check appropriate column)		
	Yes	No	Unknown
1. Was original admission for diagnosis only?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Could all services have been done on an outpatient basis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Diagnostic studies:			
a. Were all obligatory diagnostic studies done prior to admission?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Were all studies ordered as soon as possible after admission?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Were all studies done as soon as possible after being ordered?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Have reports been provided promptly by:			
1. Laboratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Radiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Electrocardiography	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Pathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have diagnostic studies been ordered unnecessarily?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have consultations been ordered promptly when required?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have consultations been rendered promptly when ordered?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If no, was it a. Prior to transfer to _____ Service?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. While on _____ Service?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Was the period between admission and surgery prolonged?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, was delay due to:			
a. schedule only?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. clinical status to patient?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. consultation problem in X-Ray?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. problem with specialty consultation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Is the postoperative period prolonged?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, is this due to:			
a. complications (diagnosis and treatment)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. transfer problem to other service?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. social or family factors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Does the record show prompt treatment by attending physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Does the record show frequent visits by attending physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Could patient's stay be shortened by indicated transfer to Nursing Home, Convalescent Home or Chronic Disease Facility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Could patient's stay be shortened by use of visiting nurse, homemaker or home care service?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Is stay prolonged due to insurance coverage or welfare status?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Is discharge indicated now?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Is discharge indicated within 48 hours?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Approximate number of additional days which might be expected from today _____			
17. Date for re-review _____			
18. Recommend action by Utilization Committee (or comments):			

SURGERY

SUMMARY OF REVIEW BY DEPARTMENTAL UTILIZATION COMMITTEE

Did Utilization Appear To Be Excessive?

Yes☐No☐If answer is NO — stop here

If yes, Explain: _____

Recommended Disposition:

No Action Necessary _____, Refer to Utilization

Committee _____

_____. M.D.

Disposition by Utilization Committee.

No Action Necessary _____

Refer to: Chief of Service

Medical Record Committee

Administrator

Attending Physician

Other _____

Comments: _____

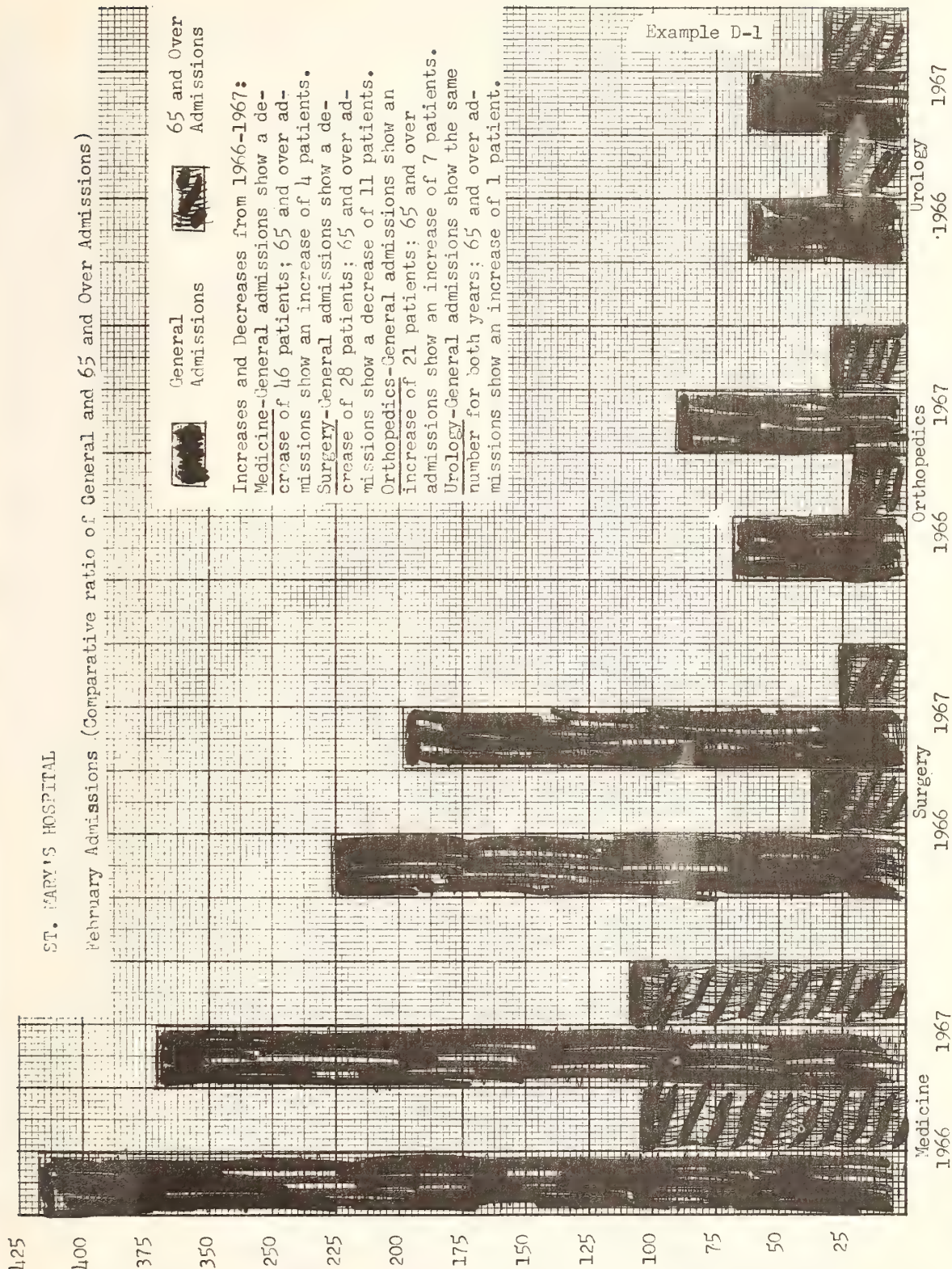
_____. M.D.

* Day 1 refers to the day after admission

Day 2, the second day after admission, etc.

ST. MARY'S HOSPITAL

February Admissions (Comparative ratio of General and 65 and Over Admissions)



Example D-1

APPENDECTOMY: Code 45.1 APPENDICITIS: Code 550.0, 550.1 (acute) OTHER DISEASE OF
552 (Chronic) APPENDIX: Code 553
SEPTEMBER, 1969:

There were 11 cases of acute appendicitis. Nine of these were confirmed
by pathological examination. (Approx. 82%)

(Pathology codes the tissue as Code 1: Acute, Code 2: Chronic, and Code 3:
No disease.)

There was 1 case of chronic appendicitis and 1 case for other disease of
the appendix in which the appendix was removed.

LENGTH OF STAY FOR CASES IN WHICH APPENDECTOMY ALONE WAS PERFORMED: 9.1 days

WBC's for all acute appendicitis cases: 22,000 (path. code 1)
9,000 (path. code 1)
18,000 (path. code 1)
18,000 (path. code 1)
7,000 (path. code 2)
17,000 (path. code 1)
16,000 (path. code 1)
14,000 (path. code 1)
16,000 (path. code 1)
12,000 (path. code 1)
18,000 (path. code 2)

(PAS makes available the WBC in thousands.)

PAS records only the number of patients who receive antibiotics or other
drugs during the patient's hospital stay. We cannot differentiate at what
point they were given.

5 out of the 12 appendicitis cases received antibiotics during their stay.

There was 1 postoperative wound infection. No other complications.

OCTOBER, 1969:

There were 8 acute appendicitis cases. 6 of these received a pathology
code of 1; 1 received a code 2 and the other a code 3. (See above for
meanings)

There were no cases diagnosed as chronic. One other case necessitated
removal of the appendix, but was not diagnosed as appendicitis. It
received a Code 3 by the pathologist.

LENGTH OF STAY FOR CASES IN WHICH APPENDECTOMY ALONE WAS PERFORMED: 6.1 days.

WBC's for acute appendicitis cases:	7,000 (path. code 1)	These cases were
	11,000 (path. code 1)	given the final
	11,000 (path. code 1)	diagnosis of acute
	18,000 (path. code 1)	appendicitis.
	6,000 (path. code 3)	preoperative
	17,000 (path. code 2)	diagnosis not coded.
	11,000 (path. code 1)	
	14,000 (path. code 1)	

3 out of the 8 appendicitis cases received antibiotics during their stay.

There were no post-op. wound infections or complications.

Commission on Professional and Hospital Activities

Vol. 5, No. 10 20 December 1967

ACUTE CORONARY OCCLUSION: Its Management In North Carolina

This *Record* issue is an adaptation of an exhibit first shown at the 1967 Convention of the Association of American Medical Colleges.

The Program Coordinator for a
Regional Medical Program (or a
Director of Continuing Education)
needs, from the region served,
information for

Program Planning
Medical Problems
Medical Practice
Program Evaluation

For the general hospital sector,
the Professional Activity Study
(PAS) can serve as the nucleus
of the information system.

The following data describe the
management of patients admitted
for acute coronaries in a sample
of hospitals from one RMP region,
North Carolina.

Notes:

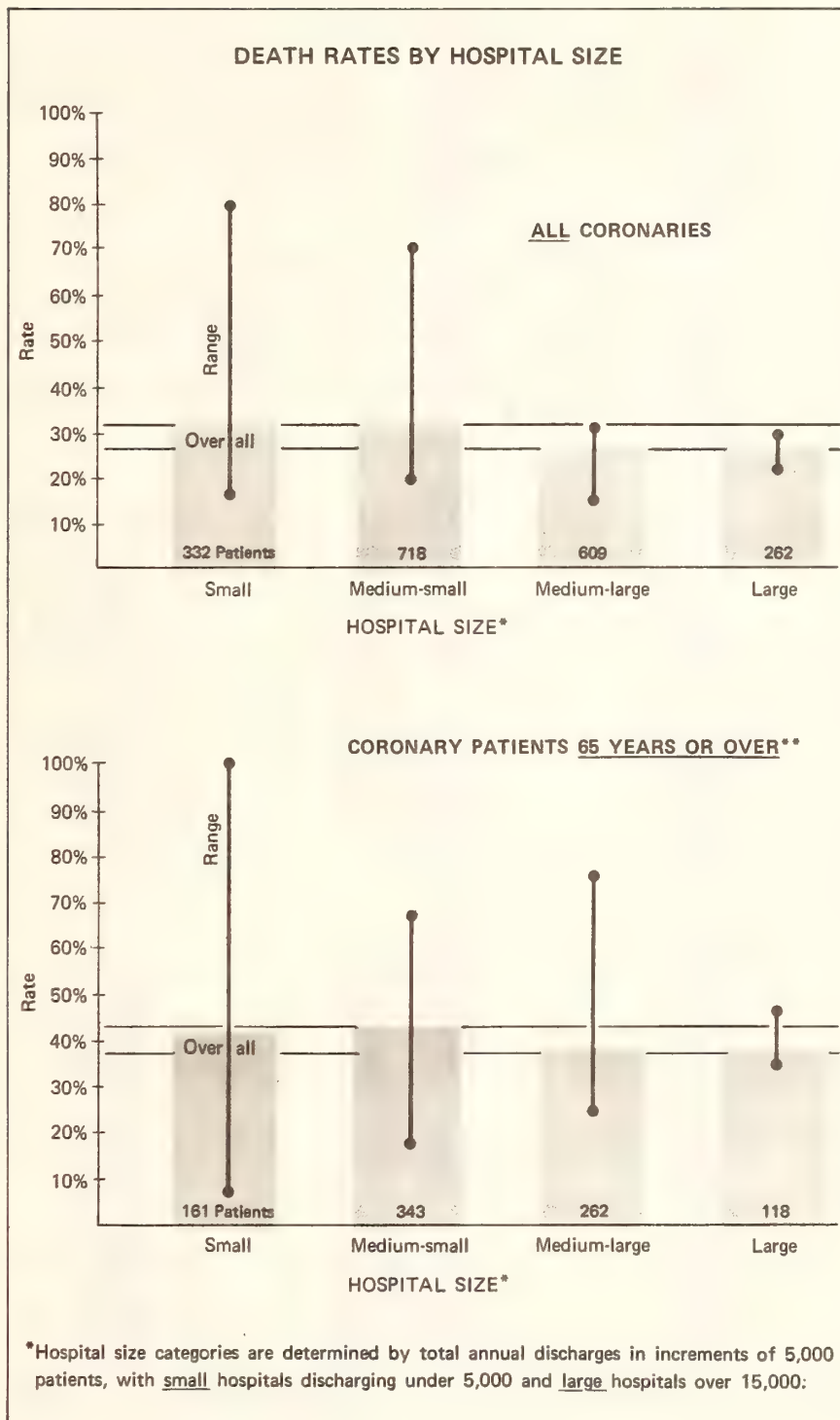
1. These data are compiled from individual PAS-MAP Case Abstracts prepared from completed clinical records by medical record department personnel. They are influenced by the quality of the medical records and of the abstracting. Despite errors in both steps, this process (abstracting by clerical personnel) is the most practical approach to a continuous information system.
2. All of the individual ("low" and "high") hospital statistics shown are available in routine reports provided to the participating hospitals. Most of those used here are taken from the quarterly reports in the Medical Audit Program (MAP) report series which are also produced by computer from the one source document, the PAS-MAP Case Abstract.
3. The information system covers all hospital discharges, so profiles can be developed equally well on any diagnosis, operation or other axis permitted by the content of the case abstract.
4. Data in addition to that specified by the case abstract can also be carried in the system.

BASE DATA

Hospitals Studied:	44
Time Period: Jan-June	1967
Total Patients Discharged: (excluding maternity and newborn)	113,324
Total Deaths: (excluding maternity and newborn)	4,355
Death Rate:	3.8%

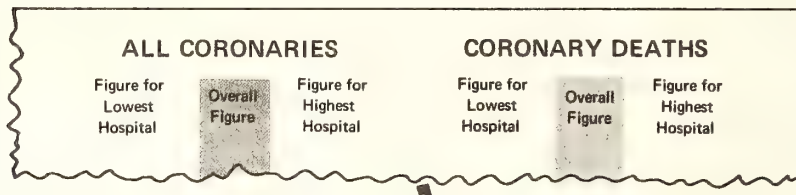
DATA ON CORONARY PATIENTS

Total patients discharged with a final diagnosis (explaining admission) of Acute Coronary Occlusion	1,921
Acute Coronary patients as a percent of total patients	1.7%
Number of coronary patients per hospital ranged from 10 to 128	
Deaths, Acute Coronary	552
Coronary deaths as a percent of total deaths	12.7%
Overall Coronary death rate	29%
Patients under 65	1,037
Death rate under 65	18.6%
Patients 65 and over	884
Death rate 65 and over	40.6%
Coronary death rates per hospital ranged from	14%to80%



The Panels which follow are set up to give overall coronary data and ranges where appropriate. Coronary deaths are compared with all coronaries.

Variations among hospitals may be due to location, patient mix, medical practice, and facilities. Here are clues to further investigation and educational efforts.



Item	ALL CORONARIES			CORONARY DEATHS		
	Figure for Lowest Hospital	Overall Figure	Figure for Highest Hospital	Figure for Lowest Hospital	Overall Figure	Figure for Highest Hospital
% Males	42	68	93	17	63	100
% Females	7	32	58	0	37	83
% 65 years or older	18	46	85	20	65	100
Average stay, days	6.6	17.1	22.8	1.0	6.5	16.3
Median stay, days	9	20	26			

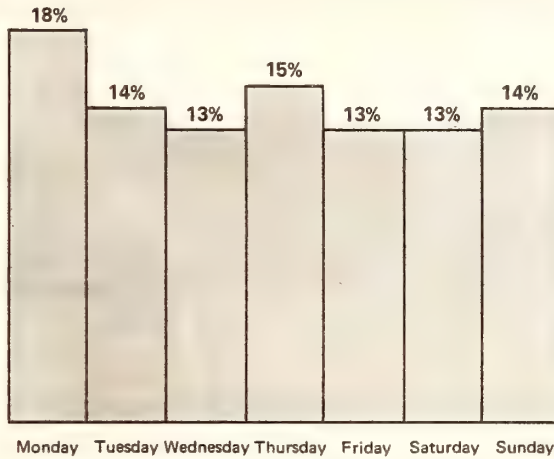
% not meeting JCAH minimum lab requirements	0	12	30	0	36	75
% with urinalysis	70	89	100	25	66	93
Number of sugar positive, no repeat urinalysis		71			26	
Number of sugar positive, no blood sugar test		23			9	
Number of albumin positive, no repeat urinalysis		221			100	
% with Hgb. or Hct.	77	92	100	25	76	100
% with WBC	77	92	100	25	75	100
% with WBC 10,000 or over	15	52	64	20	65	79

(Example D-3-5)

% with blood pressure recorded on admission	89	97	100	68	93	100
% with diastolic blood pressure 100 mm or over on admission	9	24	47	0	21	44
% with EKG	62	91	100	33	75	100
% with Funduscopy		33			26	
% with Transaminase, LDH	10	79	94	0	49	92
% with Cholesterol, Lipids		30			10	
% with Blood sugar	5	57	89	0	42	79
% with Nitrogen derivatives	18	62	91	0	50	75
% with Consultations	0	19	46	0	17	50
% with Chest X-ray	13	54	81	0	40	75
% given Anticoagulants	0	56	87	0	29	100
% with Prothrombin time	8	61	85	0	31	80
% Monitored	0	7	67	0	7	71
Number with Cardiac pacemakers, defibrillators		24			12	
% given Oxygen therapy	11	64	83	13	67	100
% given Cardiac regulators	9	47	70	0	56	100
% given Hypotensives	0	4	20	0	4	25
% given Vasodilators	2	25	55	0	17	60
% given Diuretics	2	23	60	0	30	75
% given Parenteral fluids	4	23	60	11	43	100
% given Antibiotics	12	27	52	0	33	83
Number transfused (includes whole blood and packed red cells)		34			25	
Number transfused with packed red cells		8			3	

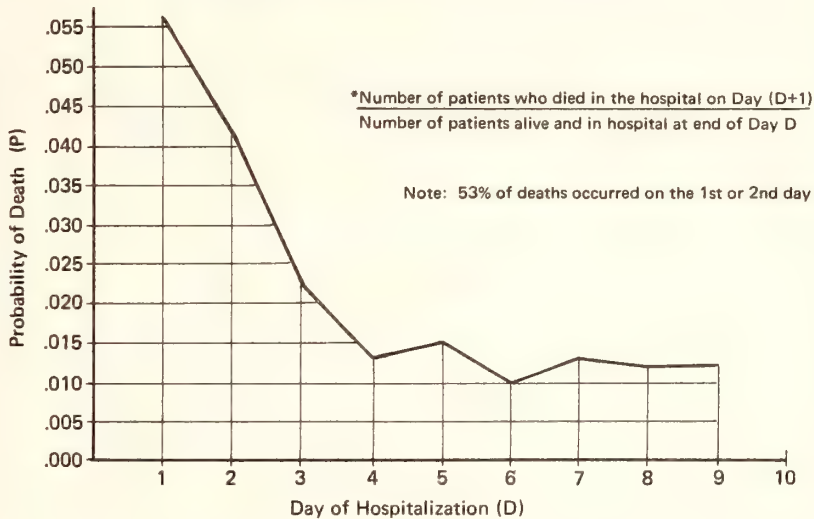
CORONARY CARE UNITS vs. INTENSIVE CARE UNITS vs. NORMAL CARE				
HOSPITAL GROUP				
	with Coronary Care Units (5 hospitals)	with only Intensive Care Units (6 hospitals)	All Others (33 hospitals)	
Coronary Patients	382	326	1,213	
PERCENT	% Monitored	24	13	1
	% with EKG	94	89	90
	% with Transaminase, LDH	86	84	75
	% given Anticoagulants	62	63	53
	% with Prothrombin time	67	69	58
	% given Cardiac regulators	56	53	42
Deaths	94	87	371	
DEATH RATE	Lowest Hospital	20%	14%	14%
	Overall	25%	27%	31%
	Highest Hospital	29%	42%	80%

DISTRIBUTION OF CORONARY PATIENTS BY WEEKDAY OF ADMISSION



HOSPITALIZED ACUTE CORONARY OCCLUSION

Probability of death within the next 24 hours*



Vergil N. Slee, MD,

Director, Commission on Professional and Hospital Activities

D'Anne Schick,

Research Analyst, Commission on Professional and Hospital Activities

Ladd W. Hamrick, Jr., MD,

Chairman, Committee for Evaluation of the Quality of Practice,
North Carolina Society of Internal Medicine

Marc J. Musser, MD,

Coordinator, North Carolina Regional Medical Program

HYPERTENSION DOCUMENTATION

Does the attending physician record all pertinent diagnoses for each of his patients? In the case of hypertension, an examination of more than one million patient records indicates that often he does not.

The PAS Case Abstract contains information on hypertension independent of diagnosis. For example, patients whose diastolic blood pressure is 120 mm or higher and patients given antihypertensive drugs are probably hypertensive even though they may not have a hypertension diagnosis recorded.

Records of all patients, excluding newborn, discharged from medium-large PAS hospitals were selected for the period January through June 1968. Studied were patients whose diastolic blood pressure was 120 mm or higher upon admission and patients who received antihypertensive drugs. Hospitals with fewer than 25 patients in either group were eliminated from study, leaving 185 hospitals. For both groups of patients in each hospital, the proportion having a diagnosis of hypertension was calculated, and percentile rankings were established.

PATIENTS WITH HYPERTENSION

Patient Group (1)	Total Patients (2)	Proportion with Recorded Diagnosis of Hypertension		
		10th Percentile Hospital (3)	50th Percentile Hospital (Median) (4)	90th Percentile Hospital (5)
Diastolic pressure 120 mm or higher	15,612	26 %	36 %	50 %
Given Antihypertensives	18,722	33 %	47 %	63 %

The recording of a diagnosis of hypertension is generally poor in each patient group, but better documentation is obtained for patients falling into both groups. Of the 3,279 patients with both high diastolic blood pressure and antihypertensive drugs, the proportion of patients with a diagnosis of hypertension was 71% in the median hospital.

PAS hospitals should use their semiannual Diagnosis Index to find the percent of high blood-pressure patients with a diagnosis of

hypertension. To test any selected diagnosis group, look for patients with code 5 or higher in column 31, then look in columns 1 through 6 for a diagnosis of hypertension.

To find the percent of patients with antihypertensive drugs and a diagnosis of hypertension, turn to the hypertension diagnoses in the semiannual Diagnosis Index. Count all patients with code H or B in column 62, divide by the total found in box 46 of the semiannual Discharge Analysis B report, and multiply by 100.

NOTES

Hospital size is determined by total annual discharges. *Medium-large* hospitals discharge from 10,000 to 15,000 patients.

For purposes of this study hypertension was defined as ICDA-719 codes 442.0–447.0 and 642.0. For 1969 use H-ICDA codes 400.0–405.0.

Antihypertensive drugs are recorded in item 37, code 6, of the PAS Case Abstract. Diuretics were not included as antihypertensives. For a list of antihypertensive drugs consult the *PAS and MAP Manual*, Appendix I.

Victor A. Van De Moortel



As a service to the Utilization Committee of _____, the Hospital Utilization Project has analyzed the results of a review conducted by Committee members of the stay of 48 patients classified acute myocardial infarctions discharged July - December, 1966.

Employing criteria developed by the Specialty Panel in Internal Medicine, the Committee examined the medical record of each patient and evaluated the appropriateness of the admission, the treatment and length of stay, including complications having a possible effect on the latter. A case review worksheet supplied by HUP was completed on each patient. These worksheets constitute the major source of the data for this report.

Of the 48 worksheets submitted, three were found inappropriate and excluded. One was for a 75-year-old female who expired 24 days after admission (no deaths were to be included), and the others were two cases, in the judgment of reviewers, inappropriately classified as myocardial infarcts.

Of the 45 patients considered, age ranged from 38 to 88 years. Sex of the patients was 31 male and 14 female. Average length of stay was 32.7 days.

Table I

Distribution of 45 Patients with Acute Myocardial Infarction
by Age, Sex and Average Length of Stay

<u>Age</u>	<u>M</u>	<u>F</u>	<u>Total</u>	<u>Per Cent of Total</u>	<u>Average Length Of Stay (Days)</u>
44 and under	4	--	4	8.9	32.5
45 - 54	8	2	10	22.2	28.8
55 - 64	9	5	14	31.1	32.4
65 - 74	7	3	10	22.2	33.6
75 and over	<u>3</u>	<u>4</u>	<u>7</u>	<u>15.6</u>	<u>37.3</u>
	31	14	45	100.0	32.7

Comment

Average length of stay of all myocardial infarct patients (86) discharged live from _____ July through December, 1966, was 26.2 days, considerably shorter than the average stay of the above 45 patients. In fact, only 8 of the 45 cases stayed less than 26 days, indicating that a disproportionately larger number of long stay cases was selected, intentionally or unintentionally, for the sample.

Age of patients could have been a significant factor influencing length of stay. Seventeen of the patients were 65 years of age and over. While their average stay tended to be longer, as might be expected, they did not account for a disproportionately larger share of the patient days. Patient age per se, therefore, did not seem a significant factor influencing length of stay.

Males predominated in the sample, constituting 68% of the total. Their average length of stay was 30.6 days. The 14 females stayed an average of 37.1 days.

Medical Factors Influencing Stay

Other factors having been eliminated, attention was directed to size of infarct and possible complications influencing length of stay.

Of the 45 cases, size of infarct was recorded in only 37 cases. Of these, 10 were rated "small," 24 were rated "moderate" and 3 rated "massive," as follows:

Table II

Comparison of Length of Stay of 45 Myocardial Infarct
Patients by Size of Infarct

Length of Stay (Days)	No. Of Pts.	Per Cent Total	Size of Infarct			Not Recorded
			Small	Mod.	Mass.	
20 - 24	7	15.0	1	4	--	2
25 - 29	13	29.0	7*	5	--	1
30 - 34	12	27.0	2	7**	2	1
35 - 39	7	15.0	--	4	1	2
40 - 44	3	7.0	--	2	--	1
45 and over	3	7.0	--	2	--	1
	<u>45</u>	<u>100.0</u>	<u>10</u>	<u>24</u>	<u>3</u>	<u>8</u>

* one judged "small to moderate".

** reviewer not sure of "moderate" in one case.

Comment

The normal range of stay for myocardial infarct cases is 20 - 24 days. As can be seen, only 7 of the 45 cases fell within this range. The majority, 25 cases, fell within the 25 - 34 days stay range, and 13 cases (29%) exceeded this range.

Of the 10 patients with "small" infarcts, 9 or (90%) stayed 25 - 34 days, and of those rated "moderate," 12 (or 50%) stayed 25 - 34 days. In other words, the overall pattern of lengthened stay was due to the longer stay of 21 infarcts rated "small" and "moderate" in the 25 - 34 day range. This is highlighted by the following rearrangement of the same data, with the "not recorded" cases removed.

Length-Of-Stay Distribution (In Days)

Size of Infarct	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 & over
10 "small"	1	7	2	--	--	--
24 "moderate"	4	5	7	4	2	2
3 "massive"	--	--	2	1	--	--
37	5	12	11	5	2	2

The 5 "typical stay" cases falling within the 20 - 24 days stay range were then eliminated and the remaining 32 cases examined with regard to complications. It was found that 24 of the 32 cases had one

(Example D-4-4)

or more complications, but there were no complications in 8 of the cases. These 8 cases were distributed in the above length-of-stay comparison as follows: (uncomplicated cases in parentheses):

Size of Infarct	20 - 24	25 - 29	30 - 34
10 "small"	1	7 (4)	2
24 "moderate"	4	5 (2)	7 (2)
3 "massive"	--	--	2

It is to be noted that the stay of the uncomplicated cases coincides exactly with the two ranges identified above as being the source of the problem. It may reasonably be inferred, therefore, that the overall pattern of lengthened stay was at least partly due to the longer than average stay of uncomplicated cases.

Evaluation of Appropriateness of Stay

To test the inference arrived at statistically, HUP turned to the reviewers' evaluations of the appropriateness of stays of these 8 uncomplicated cases and found that 4 of the 8 were judged overstays. Of the total cases evaluated, 31 were judged appropriate and 12 were considered overstays, or a ratio of about 2.5 to 1.

Day of Discharge

Since extra-medical factors may also have had an influence on length of stay, HUP analyzed day of discharge for the 45 cases definitely classified as myocardial infarct, with the following result:

<u>Day of Week Discharged</u>	<u>No. of Patients</u>
Monday	5
Tuesday	3
Wednesday	3
Thursday	13
Friday	4
Saturday	9
Sunday	8
	<u>45</u>

Rather than an even distribution, 66% of the patients were discharged Thursday, Saturday, and Sunday, suggesting that custom and convenience of both patient and physician were factors in determination of stay as much as medical readiness for discharge.

Summary

Average length of stay of 1,285 myocardial infarct patients discharged live from 20 Pennsylvania hospitals of over 200 beds for the period July - December, 1966 was 22.3 days. Average length of stay for 86 MI patients discharged live from CVMH in the same period was 26.2 days. Average stay of the 45 patients in the sample was 32.7 days.

Typical stay of MI patients is 20 - 24 days. All but 7 of the 45 MI patients in the sample exceeded this range.

Age of patients in the sample was not a significant factor influencing length of stay. Significant factors were complications, present in 32 cases; size of infarct, rated "moderate" in 24 cases; the lengthened stay of 8 uncomplicated cases; and the influence of custom and convenience on day of discharge.

Appropriateness of stay was evaluated in 43 of 45 cases, of which 31 were judged appropriate and 12 overstays. Only 4 of the 8 uncomplicated cases were included in the latter figure.

9/26/69

HOSPITAL UTILIZATION PROJECT

ISSUE: No. 2 DATE: 2/69
REPORT REFERENCE CODE: MW-01

GYNECOLOGICAL PROCEDURES

At the request of one of the hospitals associated with the H.U.P. program, data was recently compiled relative to the volume and length of stay characteristics for certain Gynecological procedures. An additional analysis was made according to the pay status of the patient.

For purposes of this study, a number of specific surgical procedures were used as indicators for identifying and analyzing experience.

The procedures used for this study were:

<u>I.C.D.A. CODE</u>	<u>DESCRIPTION</u>
38.1	Partial Mastectomy
38.2	Complete Mastectomy
38.3	Radical Mastectomy
70.0-75.8 (Inclusive)	Operations on Female Genital Organs Excluding Obstetrical
95.4	Gynecological Implants of Radioactive Substance

Data was compiled from discharges occurring during the period of January - June, 1968, at six selected hospitals of comparable size, location and services.

There were a total of 3,456 cases on which these selected procedures were performed at the six hospitals during the study period. These cases represented 31,140 days of patient care with an average length of stay of 9.0 days. The average pre-operative stay was 2.7 days.

(Example D-5-2)

The following table summarizes the data for each of the selected surgical procedures.

PROCEDURE	TOTAL CASES	TOTAL DAYS	AVERAGE DAYS STAY	AVERAGE PRE-OP STAY
38.1	541	3,111	5.8	2.3
38.2	47	671	14.2	3.7
38.3	111	1,839	16.6	2.9
70.0-75.8	2,729	25,244	9.3	2.7
95.4	<u>28</u>	<u>275</u>	<u>9.8</u>	<u>3.5</u>
TOTAL	3,456	31,140	9.0	2.7

A comparison by hospital indicates a difference of almost 2 full days in the average length of stay with a low of 8.4 days to a high of 10.2 days. It's interesting to note that the two hospitals with the highest volume of cases have the shortest average length of stay and the hospital with the lowest volume has the longest stay.

Also, it should be noted that the hospital with the longest average stay has one of the lower average pre-op stay.

HOSPITAL	TOTAL CASES	TOTAL DAYS	AVERAGE DAYS STAY	AVERAGE PRE-OP STAY
A	308	2,890	9.4	3.2
B	846	7,595	8.5	2.5
C	691	6,210	9.0	2.8
D	751	6,288	8.4	2.6
E	619	5,701	9.2	2.7
F	<u>241</u>	<u>2,456</u>	<u>10.2</u>	<u>2.6</u>
TOTAL	3,456	31,140	9.0	2.7

(Example D-5-3)

The following table is a breakdown of these patients according to pay status identified at time of discharge.

<u>PAY CLAS</u>	<u>NUMBER OF CASES</u>	<u>% OF TOTAL</u>	<u>NUMBER OF PAT. DAYS</u>	<u>% OF TOTAL PAT. DAYS</u>	<u>AVERAGE DAYS STAY</u>
Self-Pay	114	3.2%	1,061	3.4%	9.3
Blue Cross	1,945	56.2	16,455	52.8	8.4
Commercial	856	24.7	7,212	23.2	8.4
Medicare	303	8.7	4,111	13.2	13.5
Other	238	6.8	2,301	7.4	9.7

Copies of the detailed report can be obtained by requesting SPECIAL -
REPORT M¹-01

Research Department
Hospital Utilization Project
3530 Forbes Avenue
Pittsburgh, Pennsylvania 15213

_____, M.D.
Chief of Surgery

February 24, 1970

Dr. _____
Chief Pathologist
_____ Medical Center

Dear Dr. _____

Enclosed is a copy of PAS data reviewed in January, 1970 by the
Surgical Audit Committee.* The topic was acute appendicitis.

A chart by chart review of the September and October, 1969 cases
operated upon with the diagnosis of acute appendicitis revealed:

- (1) PAS data are not entirely accurate. Errors in coding of final diagnosis and white blood counts have been demonstrated. Examples of errors included: (a) case of appendicitis was coded on the face (index) sheet as "chronic" (instead of 3 listed by PAS); (b) three cases were reported as histologically normal but coded on the bottom of the pathology sheet as abnormal. Two such examples are appended.
- (2) The diagnostic skill of the surgical staff appeared to be good. Although 5 appendices (of 22) were not histologically acutely inflamed, 3 of these were reported grossly by the surgeons to be partially obstructed by fecaliths or fecal material; and 1 was reported as "healed appendicitis" on histological examination.
- (3) The average stay of 9.1 days for September (vs. PAS national average of 6.5 days) is accounted for by 1 patient who had prolonged fever and wound drainage.

The data collected for PAS are also appended.

Recorder

M.D.

(*See Example D-2)

ACUTE MYOCARDIAL INFARCTION

The University of Michigan Utilization Review Handbook was used as a guide to evaluate 55 patients that were either admitted or discharged with the diagnosis of acute myocardial infarction.

In a preliminary meeting the panel agreed that the questionnaire was satisfactory for an evaluation of these patients.

Concerning the History

1. In 7 cases the history was felt to be grossly inadequate in all aspects.
2. In 9 cases no reference was made to character, onset, radiation, and duration of pain.
3. In 9 cases no reference was made to dyspnea, vomiting, sweating, syncope, leg pains, hemoptysis or dependent edema.
4. In 6 cases no reference was made to previous history of angina, myocardial infarction or diabetes.
5. In 9 cases no reference was made to cerebrovascular insufficiency or intermittent claudication.

The group felt that reference to cerebrovascular insufficiency and intermittent claudication was not mandatory for a history of myocardial infarction.

Histories were inadequate in too high a percentage: 13% generally, and in pertinent specific aspects: 17%.

Concerning the Physical Exam

1. Physical exams were grossly inadequate in 6 cases.
2. No specific reference was made to signs of shock, pallor, apprehension, restlessness, pulse rate, sweating, cyanosis and tachypnea in 16 cases.
3. No specific reference was made to blood pressure in both arms in 28 cases.

Physical exams were grossly inadequate in 11% and to certain specific essential aspects as high as 30%.

The group felt that blood pressure in both arms was not absolutely essential.

Lab Work

1. In 6 cases the lab evaluation was grossly inadequate.
2. In 7 cases EKG on admission and discharge was not done.
3. Serum enzymes were not done in 3 cases. (these patients expired the first day)
4. 2 hr. p.p. blood sugars were not done in 17 cases. All had fasting blood sugars.
5. Serum lipids were not done in 36 cases.
6. Serum electrolytes were not done in 24 cases.
7. Prothrombin times were not done in 14 out of 50 cases.

Lab work was grossly inadequate by 11%.

It was suggested that the laboratory inform the medical staff what lipid studies can be done at the hospital and what is the significance of such.

Serum electrolyte studies, it was felt, is not essential in the uncomplicated myocardial infarction.

Concerning Radiology

A chest X-ray was not done in 6 cases.

It was felt by the group that chest X-rays should be done prior to discharge to evaluate heart size, aneurysm, etc.

Special Procedures

Cardiac monitoring was not done in 13 cases.

It was felt by the group that all cases be monitored initially.

Length of Stay

Out of 55 cases:

1. Expired - 11

(Example D-7-3)

2. Small infarct - 22. Average stay was 21.6 days, with a range of 15 to 30 days. As recommended in the study, 14 to 21 days.
3. Large infarct - 18. Average length of stay 27.4 days, with a range of 20 to 44 days. As recommended in the study, 21 to 26 days.
4. Diagnosis doubtful of myocardial infarction - 4.

Complications

Early Complications

- Shock - 15
- Coronary pain or unusually long duration - 17
- Cardiac failure - 14
- Serious Arrhythmias - 14
- Other heart disease - 9
- Unusually large infarction (by EKG or enzymes) - 13
- Extension of infarction - 2

Late Complications (beyond 1st week of illness)

- Cardiac failure - 6
- Serious arrhythmias - 5
- Persistent tachycardia - 1
- Difficulty in regulation of anticoagulant therapy (if prothrombin time profoundly prolonged or inadequately prolonged) - 2

Apparently all patients were discharged with normal or stable pulses and normal temperatures with freedom from pain except for perhaps occasional angina.

It was felt that all admissions were appropriate.

Hospital services were inappropriate in 22 cases. The leading cause of inadequacy was the lack of cardiac monitoring. In a few cases no monitors were available.

Length of stay was inadequate in 9 cases; 4 were overstay, and 5 cases were understay.

RECOMMENDATIONS

1. In general, the University of Michigan outline is appropriate for indicated Hospital Services (histories, physical, laboratory, and work-up).
2. All cases should be monitored initially.

3. More care and detail is necessary for histories and physicals.
4. Lidocaine should be available for IV therapy (for arrhythmias) in the ICY.
5. In several cases, consultation should have been obtained.
6. Length of hospital stay was inappropriate in 18.7%, with overstays in 8% and understays in 10%.

MEDICAL AUDIT REPORT
(EXAMPLE COVER SHEET)

March 7, 1966

It is not the purpose of the committee to criticize individuals but to evaluate the overall quality of care. We are also interested in the effect of the studies, in an educational sense, on patient care. Terms such as overstay, understay and inappropriate and inadequate are used deliberately to emphasize the difference between the records of care and the criteria. This report tabulates these differences, whether due to differences of opinion (which we respect) or from poor judgment, accident, oversight or poor record keeping.

Chairman
Medical Audit Committee

AUDIT COMMITTEE REPORT TO THE EXECUTIVE COMMITTEE ON
CHOLECYSTITIS AND CHOLELITHIASIS
(EXAMPLE)

March 7, 1966

There are 80 cases selected from the last 6 months of admissions to the hospital in 1965 with the diagnosis of cholecystitis or cholelithiasis. This is the subject of the second Audit Committee Report (the first was in 1963) on this diagnosis. You will recall that the criteria for evaluation were published for each and every staff member before the July 1, 1965, beginning of this study. The response of the staff is of keen interest to the Audit Committee.

Evaluation of Admissions

- 92% 74 cases of the 80 total admissions for cholecystitis were appropriate admissions.
- 8% 6 cases of the 80 were inappropriate and accounted for a total of 32 hospital days.

Length of Stay Evaluation

- 85% 68 cases of the total were considered appropriate in terms of stay.
- 3% 2 cases were considered preoperative overstay by an average of 5.2 days.
- 1% 1 case was considered postoperative overstay by 3.5 days.
- 4% 3 cases were considered postoperative understay by an average of 1.5 days.

In terms of compliance with the criteria established for optimum care and utilization of hospital facilities, the study reveals that 45 of the 80 cases studied failed to receive specific elements of optimum care. This occurred in 36% of private pay patients, 60% of Blue Cross patients, and 50% of commercial insurance patients, which is certainly no indication that too many hospital procedures are undertaken because of third party coverage.

EXAMPLE AUDIT COMMITTEE REPORT (con't)

Most omissions relate to the adequacy of roentgenographic examinations. Thirty-three patients had no chest roentgenogram, 6 patients had no cholecystogram, 19 had no upper gastrointestinal roentgenogram, and 28 had no barium enema.

There were 12 cases in which a serum amylase should have been done, 18 in which liver function tests should have been done, and 6 in which electrocardiograms should have been done.

Only 2 cases failed to have a complete blood count and only 2 failed to have a urinalysis.

When compared with the initial study in 1963, certain trends are apparent:

There are slightly less inappropriate admissions in 1965.

There is a larger percentage of appropriate length of stay in 1965 (70% in 1963, 85% in 1965)

There is less understay postoperatively in 1965 (6.9% vs. 4%).

There is less preoperative overstay in 1965 (11% vs. 3%).

There is no change in postoperative overstay (but this is only 1% in each year).

The emphasis on the areas of preoperative overstay, inappropriate admissions and postoperative understay following the study of 1963 seems to have paid off.

More patients received more adequate services in 1965 as compared to 1963. In 90% of the cases in 1963, there were omissions in care; in 1965, only 57% of the cases are judged to have such omissions. This is a remarkable change. It is hoped that the result reflects to some extent the medical staff's acceptance of this self-evaluative function of the Audit Committee.

Chairman, Medical Audit Committee

(List of Committee Members)

SINAI HOSPITAL OF BALTIMORE, INC.

BELVEDERE AVENUE AT GREENSPRING

BALTIMORE, MARYLAND 21215

PHONE: 367-7800

March 18, 1970

The Department of Surgery began intensively exploring the concept of Surgical Utilization Review in 1965 and reviewed their records for the average stays for several specific surgical procedures. During the 1965 period the average length of stay for adult hernias (those performed over the age of 14) was 8.75 days. In 1966 the average for length of stay for the same group of patients was 8.60 days.

The Hospital started generalized Utilization Reviews in May of 1966. In 1967 the average stay for inguinal hernias had been lowered to 8.3 days and in 1968 had fallen to 8.05 days. During the first three quarters of 1969 the average fell drastically to 6.6 days. It is interesting to note that the number of cases done in first three quarters of 1969 exceeded the total number of cases done in the entire years of 1965, 1966, 1967 or 1968.

Of equal interest however, is to be noted that the median stays for 1965 in patients 65 or over was 9.5 days. This fell to 8.7 days in 1966, was 8.7 days in 1967, 8.3 days in 1968 and data available so far show 8.3 days in 1969.

As was anticipated the Staff could adapt itself and its patients to shortening the average length of stay in the patients between the ages of 14 and 65; however, this was not so in those 65 or older who require a slightly longer work-up, are slower to ambulate and reach discharge status because of medical complications.

The Surgical Utilization Review Committee feels that their work has been justified in shortening of the length of stay of patients. They feel however, that there is a irreducible limit due to the complications that may ensue after surgery and of the necessity for the diligent medical care required in caring for those in the upper age groups.

The attached statistical sheet is self-explanatory.

Sincerely yours,

M.D.
Chairman, Surgical Utilization Review
Committee

Enclosure

A CONSTITUENT AGENCY OF THE ASSOCIATED JEWISH CHARITIES



SINAI HOSPITAL OF BALTIMORE, INC.

INGUINAL HERNIA

<u>QUARTER</u>	<u>NUMBER</u>	<u>TOTAL PATIENTS</u>		<u>%</u>	<u>PATIENTS UNDER 65</u>		<u>PATIENTS 65 OR OVER</u>	
		<u>AVERAGE STAY</u>	<u>MEDIAN STAY</u>		<u>NUMBER</u>	<u>MEDIAN STAY</u>	<u>NUMBER</u>	<u>MEDIAN STAY</u>
1st - 1965	118	8.3	7.4	90	92	7.2	26	8.8
2nd - 1965	100	9.1	7.9	88	84	7.7	16	10.5
3rd - 1965	115	8.5	7.6	90	96	7.3	19	10.6
4th - 1965	99	9.1	8.0	89	84	7.6	15	10.3
1st - 1966	108	8.5	(Median stays no longer reported.)	88	(Median stays no longer reported.)		19	9
2nd - 1966	100	9.2		89			19	8
3rd - 1966	97	8.5		90			16	9
4th - 1966	98	8.2		92			24	9
1st - 1967	117	8.8		91			16	9
2nd - 1967	104	7.9		89			18	8
3rd - 1967	96	8.8		82			23	9
4th - 1967	86	7.7		92			17	9
1st - 1968	100	7.6		90			19	8
2nd - 1968	114	8.1		91			27	8
3rd - 1968	90	8.6		83			30	8
4th - 1968	97	7.9		91			25	9
1st - 1969	108	7.6		84			21	8
2nd - 1969	170	6.1		86			16	8
3rd - 1969	137	6.2		85			19	9

(Example D-9-2)

UTILIZATION REVIEW COMMITTEE
MINUTES

Example E-1

_____ Hospital
_____, New Jersey

Minute of
Hospital Utilization
Review Committee Meeting
January 21, 1969

UTILIZATION
REVIEW
COMMITTEE
MEETING

A meeting of the Hospital Utilization Review Committee was held on Tuesday, January 21, 1969 at 8:20 a.m. at the hospital.

JANUARY 21,
1969

Those present were as follows: Drs. B_____, C_____, H_____, P_____, and R_____; Misses A_____ and H_____; Messrs. K_____, S_____, and S_____. Dr. R_____, Co-Chairman, presided.

PRESENT

The minutes of the previous meetings of December 17, 1968 were read and amended as follows:

APPROVAL
OF MINUTES

In the discussion of the proposed publication of utilization statistics, the Committee's recommendation was amended to read as follows:

PUBLICATION
OF UTILIZATION
STATISTICS

Propose that: Statistics of those physicians rejected on utilization review shall be tabulated and published, by name, in the minutes of the Quarterly Staff Meetings. In addition, a second category of physicians with records rejected for utilization referred from the Medical Records Committee to the Utilization Committee shall be tabulated and published, by name, in the minutes of the Quarterly Staff Meetings.

With the above amendment, the minutes of the previous meeting were approved as published.

Discussion then ensued on the matter of Laboratory utilization at _____ Hospital. It was decided that a representative subcommittee should be appointed to study this matter. Drs. B_____, P_____, and P_____ were named to the subcommittee.

LABORATORY
UTILIZATION

Dr. R_____ stated that he had made utilization rounds with Dr. P_____ on one occasion in an effort to facilitate earlier discharges, as the Hospital was full and admitting on an emergency basis. There were four patients on one floor who were discharged that day. The physicians approached were most cooperative and the full-bed situation was alleviated.

MORNING
UTILIZATION
ROUNDS

Utilization Review Committee

January 21, 1969

The rounds did bring to light the fact that the Staff is not making optimal use of the extended care facility at _____. Cases which are the most potential extended care candidates include orthopedic patients, recovering coronaries, postoperative convalescents, etc. The importance of using the extended care facility and Home Care for the optimal benefit of the patients, physicians, and Hospital will be stressed at the forthcoming Annual Staff Meeting.

EXTENDED CARE
FACILITY

Dr. H _____ reported that an average of 35 cases per week were reviewed during the past five weeks - a definite increase in the number of charts being reviewed. Of the 46 charts questioned, the majority of patients were sent home following the review. Two specific problems encountered by Dr. H _____ were discussed by the Committee.

REPORT OF
REVIEW OFFICER

Dr. C _____ stated that several months ago the Review Officer had asked that the Medical Records Committee review the discharged charts of those patients who had not been approved for recertification while in the Hospital. There were six such cases reviewed involving a total of five hospital days stayed after notification of rejection.

REPORT OF MEDICAL
RECORDS COMMITTEE

The Department of Surgery has indicated some dissatisfaction with the return of laboratory stat work on weekends. About six months ago, the Laboratory requested that the doctors indicate "routine stat" or "emergency" when ordering such work. What Dr. B _____ would like the Committee to discuss was (1) should the problem of stat abuse be attacked and (2) if so, what should be done. Several hospitals have some restriction on weekend stat work; i.e., an additional charge. _____ Hospital has never placed a limitation on these tests.

WEEKEND
LABORATORY
UTILIZATION

It was the Committee's consensus that the matter of chronic offenders should be approached on an individual basis by the Chairman of the Department of Pathology. The Committee agreed with Dr. B _____ that no attempt should be made to restrict stat work on weekends. The Committee also felt that Dr. B _____ should bring this matter up at the forthcoming Annual Staff Meeting, in particular to inform the Staff of the hours when the SMA-12 machine is in operation.

(Example E-13)

Utilization Review Committee

January 21, 1969

It was announced that only 20 patients have had Pre-Admission Testing (PAT) since the programs inception. This indicates very poor usage of PAT, a program that could solve the surgeons' complaints about preoperative ECG's, etc. This matter will be taken up with the Department of Surgery by the Chairman of the Department of Pathology.

PRE-ADMISSION
TESTING PROGRAM

There being no further business, the meeting was adjourned at 9:15 a.m.

ADJOURNMENT

Respectfully submitted,

D _____ R _____, M.D.
Co-Chairman

Utilization Review Committee Minutes
 General Hospital

The regular biweekly meeting of the utilization review committee was called to order at 4:30 on Thursday, July 10, 1969 by Dr. Allen, Chairman.

Members present:

Dr. Prince, Internal Medicine

Dr. Cary, Internal Medicine

Dr. Sharpe, General Surgery

Dr. Branner, Urology

Dr. Bennington, General Practice

Dr. Josephson, Anesthesiology

Miss Abigail Flagg, Medical Record Librarian

Mrs. Norma Hart, Social Service

Miss Vera Elder, Director of Nursing

Mr. Best, Administrator

- I. The minutes of the previous meeting were read and approved.

Miss Elder reported that the nursing department has been presented with the committees' recommendations concerning nursing coverage in the cardiac care unit. She said the committee would be notified of the action taken by nursing at the next meeting.

Dr. Allen reported that he had discussed the committee's laboratory findings with Dr. Gray, the clinical pathologist. Dr. Gray agreed with our committee's findings that there has been an undue delay in

reporting laboratory results to the clinicians, and promised a complete review of the reporting system as recommended by the committee. According to Dr. Allen we will be kept posted by Dr. Gray on the actions taken to correct this problem.

Dr. Allen then reported that the lecture recommended by the committee on anticoagulation therapy on an outpatient basis will be held on July 22 at 8:00 p.m. The main speaker will be Dr. Endler of the medical school. The medical staff will be notified of the lecture and arrangements will be handled by Dr. Cary.

II. The extended duration review subcommittee reviewed a total of 22 cases of extended duration^{*} since the last meeting. The following cases have been brought to the full committee to be resolved.

1. Patient #485-06-339, 54 year old male admitted on June 1, 1969 with an admitting diagnosis of myocardial infarction, which was confirmed by EKG and laboratory results. Patient placed in coronary care unit for first five days of admission and treated with appropriate therapeutic procedures. There have been no complications or sequelae following original attack and patient is now on modified bed rest and not receiving any medications. Patient is a widower who lives alone. The case was brought to the full committee because the reviewing physician felt this patient no longer needed hospital services and could be managed at home with the aid of a visiting nurse.

*(The review period is set by individual diagnosis, by a method similar to AID.)

(Example E-2-3)

Committee disposition: this patient has been hospitalized for 40 days since his attack and no longer is receiving or requires skilled observation and nursing care. Therefore, the committee feels that this patient can be managed at home with the aid of a visiting nurse. The attending physician should be so informed. Social service investigated the family situation and feels that the patient's two children are able to assist in the bedside care necessary for this patient's recuperation.

2. Patient #485-29-701, is a 68 year old female admitted because of right upper quadrant pain. Diagnostic procedures revealed cholecystitis and cholelithiasis. Patient was admitted on 6/18/69, the surgery was performed on 6/22/69, patient developed a paralytic ileus immediately post-operatively and was treated with nasogastric suction. This condition was resolved on 6/27/69 and the reviewing physician referred this case to the full committee because of the prolonged postoperative stay.

Committee disposition: the attending surgeon revealed that the patient has developed a pneumonia since the earlier review which is being vigorously treated but has not yet resolved. This information was not available on the chart. The committee finds on the basis of the pneumonia which is not resolved that this

patient requires continued hospitalization and should be re-reviewed by a subcommittee member in one week. The committee also found that vital information about the postoperative pneumonia was not readily available on the chart and that steps should be taken to correct this type of problem in the future. There is also some question that the patient's preoperative stay may have been longer than was necessary considering that the diagnosis was made the day after admission and surgery was delayed for 3 days after that time. There is nothing on the chart to justify that delay. Dr. Allen will discuss these matters with the attending physician.

3. Patient #485-72-509, 74 year old male was admitted in acute urinary retention which was relieved immediately upon admission by catheterization. Diagnostic tests were performed and a diagnosis of benign prostatic hypertrophy was made. Patient was admitted on 6/26/69 and the TUR was performed on 6/29/69 with no complications. Patient is now on a full diet and ambulatory. Case was referred by the reviewing physician because he felt the patient was ready for discharge. The attending physician was contacted and did not agree with the decision of the reviewing physician.

Committee disposition: the attending physician has now agreed that this patient should be discharged and has arranged for discharge of this patient home tomorrow. According to social service this patient lives

with his daughter and son-in-law who are able to provide adequate bedside care and attending physician will make these arrangements.

4. Patient #485-35-7070, 14 year old male admitted with a diagnosis of indirect left inguinal hernia for surgery. The date of admission was 6/30/69, date of surgery was 7/4/69, there were no postoperative complications and the patient became ambulatory 2 days postoperatively. The reviewing physician felt that this patient was ready for discharge. The attending physician was contacted but stated the reason the patient remained in the hospital was to have an EEG done on 7/14/69 for a seizure disorder which is apparently being controlled by Dilantin. The patient has not had any seizures in the last few years and there have been no complications to his surgery.

Committee disposition: The committee has recommended that this patient be discharged and have his electroencephalogram done on an outpatient basis. There was also some question that the preoperative stay in this case was more lengthy than necessary. The attending physician agreed that the EEG could be done as an outpatient and this patient is to be discharged today.

Summary of the extended duration cases reviewed for the two week period ending July 10, 1969.

Total cases reviewed - 26

Number approved by review physicians - 22

Number questioned by reviewing physicians and referred to full committee - 4

Number approved by full committee - 1

Number not approved by full committee - 3

III. Sample Review Study

Dr. Sharpe and Miss Flagg reported on the study of cholecystitis and cholelithiasis which has just been completed. Copies of the report have been distributed to the chiefs of Medicine and Surgery, the executive committee, the administrator, and a copy is attached to the minutes of this meeting. There were some unusual findings in the report which are highlighted in these minutes.

1. Approximately 64% of the patients were surgical patients and the remaining 36% had no operative procedures performed during the hospitalization. The average length of stay for the surgical patients (15.3 days) was longer than for non-surgical patients (7.1 days). (53.6% of the non-surgical patients stayed five days or less.) The overall average length of stay was 12.4 days. Twenty-six percent of the patients stayed longer than 2 weeks.
2. Eight of the surgical patients (there were 27 surgical patients in the study) had a preoperative stay of 3 or more days. In

all but two of these cases, there were no complicating factors which might justify this unusual preoperative stay.

3. There were 2 patients (8%) who developed postoperative wound infection, and 1 patient who had postoperative pneumonia. Three patients (11%) developed ileus.
4. It was found that 16 of the 42 (38%) cases were admitted as emergencies and the records did not substantiate that all these patients were in need of emergency care. As a result it is suggested that this committee undertake a study reviewing the emergency admission policies and the reasons why people who are not considered emergencies are being admitted as emergency cases.

On the basis of this study the committee reviewed the 8 cases with a preoperative stay of 3 days or longer and noted that 4 of these cases belonged to one surgeon. This physician's average length of stay was 21 days for his 7 cases. The committee decided to invite this physician to appear at the next committee meeting to discuss this matter.

The committee had instructed Miss Flagg to do a study of emergency admissions during the month of May 1969. Dr. Josephson will assist with this study and the results will be presented at the next committee meeting.

The committee was satisfied with the average length of stay for both the surgical and non-surgical cases. It was noted that the average length of stay had decreased about 1 day for both surgical and non-surgical cases in the past year.

IV. The committee then discussed the pediatric service and Dr. Bennington was requested to review the utilization of pediatric beds informally and suggest at the next committee possible studies of the pediatric service. The committee also voted to recommend that a pediatrician be appointed to the committee when the next vacancy occurs.

The committee meeting will be held at 4:30 p.m. on July 24, 1969. The meeting was adjourned at 6:30 p.m.

MEMORANDUM

TO: _____, M.D.
Chairman of Medical Audit Utilization Committee

FROM: Medical Audit Utilization Subcommittee
Department of Otolaryngology

SUBJECT: Improvement of medical care of T&A patients during
period of hospitalization.

DATE: January 13, 1970

TIME: 4:45 p.m.

The Medical Audit Utilization Subcommittee of the Otolaryngology Department held its meeting on January 6, 1970.

Minutes of the previous meeting were reviewed and the final list of criteria selected for the evaluation of the care of hospitalized T&A patients were approved. The list of criteria is enclosed. *

The charts of 527 T&A patients hospitalized at _____ were studied with regard to the selected criteria of patient care.

The following conclusions were drawn:

1. The level of medical care for T&A patients is generally considered very satisfactory.
2. The use of proper history and physical examination forms including workup of patients and progress notes must be improved.
3. The Chief of Anesthesiology must be contacted regarding the timing of the preoperative medications.
4. The accepted criteria for T&A care should be distributed to the entire Otolaryngology staff.
5. These conclusions will be forwarded to the Advisory Committee for further action.

Meeting adjourned at 6:00 p.m.

_____, M.D.
Chairman

(*See Example A-3.)

Selection of Cases by a Two-Phased Stratified Random Sampling Method

This procedure is based upon a two-phased stratified random sample, i.e. by diagnosis and by physician. It thereby takes into consideration all hospitalized cases and all physicians rendering the care during any single month for which retrospective evaluation is required. It does not require that every single case be reviewed, although it will encompass every physician who has furnished medical care; it avoids any subjective decision as to which particular case or diagnostic categories are to be reviewed.

Methodology — At the end of each month, the listings of all cases broken down by ICDA (International Classification of Diseases, Adapted) diagnostic category and by physician are inspected, with cases selected for review in the following manner:

1. When an individual physician has treated only one specific disease during the course of one month, this case will be reviewed. However, when more than one such diagnosis is treated by any one physician, *all* such cases are to be arrayed by date of hospital admission. The following sample design will then apply.
2. Where two, three, or four cases of the same diagnosis have been treated by the same physician, the *second* chronologically-ordered case will be selected.
3. Where five through nine such cases have been treated, the *first* and *fifth* chronologically-ordered cases will be selected.
4. Where ten through 19 cases have been treated, the *second*, *sixth* and *tenth* ordered cases will be selected for review.
5. Where 20 or more cases have been treated, select the *third*, *eighth*, *fourteenth* and *nineteenth* cases.

The type of data recording from the case abstract lends itself to easy inspection and application to the fulfillment of whatever criteria have been developed by the medical staff for evaluative purposes. The chronological listing by disease entity provides a ready clue for cases needing recertification as well. From this type of listing, or tabulation sheet, can be developed various profiles of physician performance and cross analyses by age, sex and other variables. At the same time, it serves as the basis for the sample selection.

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no. 8

HEALTH
INSURANCE
FOR THE AGED

GROUP PRACTICE PREPAYMENT PLAN MANUAL



U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Social Security Administration

HIM-8 (5-69)

CHAPTER 1

GENERAL INFORMATION ABOUT THE PROGRAM

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General Information About the Health Insurance Program

100. INTRODUCTION

The Social Security Amendments of 1965 (Public Law 89-97) established a new program of health insurance for persons age 65 and older. This program (Title XVIII of the Social Security Act—Health Insurance for the Aged), popularly known as "Medicare," became effective on July 1, 1966. Together with the 1967 Amendments to the Act, they provide two basic forms of protection against the costs of health care:

1. Part A—Hospital Insurance Benefits for the Aged—An individual who has applied for and has been determined to be entitled to monthly social security benefits or railroad retirement benefits (although he may not actually be receiving benefit payments, e.g., he has not retired), is automatically entitled to hospital insurance (Part A of the law) beginning with the first day of the month he attains age 65. In addition, a special transitional provision of the law permits persons 65 years and over, who could not qualify for monthly social security or railroad benefits, to obtain hospital insurance upon filing an application.

Coverage includes 90 days of inpatient hospital services in each benefit period, as well as a lifetime reserve of 60 days which can be used during any benefit period; up to 100 days of covered inpatient extended care services in each benefit period; and up to 100 home health visits within a benefit period. A benefit period or "spell of illness" is a period of consecutive days that begins with the first day on which a beneficiary is furnished inpatient services in a qualified hospital or extended care facility and ends with the close of 60 consecutive days during which the beneficiary has not been an inpatient in a hospital or extended care facility.

2. Part B—Supplementary Medical Insurance Benefits for the Aged—A voluntary plan that provides insurance coverage for a number of medical and other health services including physicians' services wherever furnished, outpatient hospital services, diagnostic x-ray tests, including portable x-ray services and outpatient physical therapy. Home health services are covered under Part B when an individual is not eligible for payment of such services under Part A.

101. ADMINISTRATION OF HEALTH INSURANCE

Responsibility for administration of health insurance for the aged including both hospital (Part A) insurance and supplementary medical (Part B) insurance has been assigned to the Department of Health, Education, and Welfare. Three constituent agencies of the Department are involved. These are the Social Security Administration, the Public Health Service, and

the Social and Rehabilitation Service. In addition, the law provides for the management of specific aspects of the program by various public and private organizations. Following is a listing of agencies and organizations participating in the conduct of the Medicare program and a brief description of their responsibilities.

101.1 The Social Security Administration.—The Social Security Administration has primary responsibility for policy formulation and the general management and operational aspects of the program. These include: determination of an individual's entitlement to benefits and the nature and duration of services for which payment may be made; establishment, maintenance, and administration of agreements with State agencies, providers of services, fiscal intermediaries and carriers; formulation of major policies regarding conditions of participation for providers, in consultation with the Public Health Service and the Social and Rehabilitation Service; development and maintenance of statistical research and actuarial programs; and general financial management of the program. The Social Security Administration also makes determinations of reasonable costs and amounts to be paid to providers and organizations that have elected to deal directly with the Government.

101.2 The Public Health Service.—The Public Health Service has the principal responsibility for the professional health aspects of the program. These include professional consultation and recommendations to the Social Security Administration in the development of health and safety, and other guidelines for determining whether providers of services meet the conditions for participation in the program; consultation and advice to State agencies concerning the application of standards for providers, coordination of program activities with other health services and activities in the State; and activities necessary in studying the utilization of hospital and other medical care services under the program.

101.3 The Social and Rehabilitation Service.—The Social and Rehabilitation Service has the primary role in hospital and medical insurance program planning, coordination and evaluation in matters that affect other federally-aided assistance programs; in assisting State agencies to achieve a coordinated approach with other health care plans under the Social Security Act; and in all aspects of program administration affecting public welfare agencies.

101.4 Advisory Group.—A non-governmental advisory group, the Health Insurance Benefits Advisory Council (HIBAC), which consists of persons eminent in hospital, medical, and other health activities, and at

least one representative of the general public, advises the Secretary of Health, Education, and Welfare on general policy in administering the program and in the formulation of regulations. The Secretary is required to consult with the Health Insurance Benefits Advisory Council in determining conditions of participation for providers of services in addition to the requirements specifically listed in the law.

101.5 State Agencies.—The States, by agreement with the Secretary, are assigned significant administrative functions to the extent that each is willing and capable of discharging such responsibilities.

Certifications are made by State agencies to the Department of Health, Education, and Welfare indicating whether hospitals, extended care facilities, home health agencies, independent laboratories, portable x-ray facilities, and organizations furnishing outpatient physical therapy services satisfy, and continue to satisfy, their respective conditions of participation in the program. This function is intended to be a natural adjunct to ongoing State activities, such as the licensing of health care facilities and the setting of standards.

Consultation services are rendered by State agencies if their agreements provide for it. Consultation with providers of services that need and request assistance to meet the conditions of participation is an integral part of the certification process.

Coordination by the States relates its activities in the performance of its functions under the program to the other programs in the State that have to do with payment for health care, quality of care, and distribution of health facilities. Coordination of these activities is essential in assuring effective and economical use of existing State facilities, and trained personnel, and in preventing duplication of effort.

101.6 Role of Part A Intermediaries.—The Part A intermediary is a public or private agency or organization that has entered into an agreement with the Social Security Administration to process Medicare claims under both Part A and Part B of providers of services, e.g., hospitals, extended care facilities, home health agencies and outpatient physical therapy providers. (Providers may elect to deal directly with the Social Security Administration.)

The intermediaries will make payments to providers on the basis of the reasonable cost of covered services and items. In addition, intermediaries will assist in the application of safeguards against unnecessary utilization of covered services, furnish consultative services to assist in the establishment and maintenance of requisite fiscal data, serve as a center for communicating with providers, conduct audits of provider records, and provide information and advice to institutions and organizations that wish to qualify as providers of services.

101.7 Role of Part B Carrier.—The law requires the Secretary to enter into contracts with carriers to serve as intermediaries in the operations and administration of the Part B program. A principal function of these carriers is to make determinations of whether charges of physicians (including hospital-based physicians), suppliers, and GPPP's for covered Part B services constitute "reasonable charges" within the meaning of the law, and to make payment. In the determination of "reasonable charges" for a GPPP, "reasonable charges" are to be related to the plan's reasonable cost.

103. LIMITATIONS TO ADMINISTRATIVE AUTHORITY

The law specifically prohibits any Federal officer or employee from exercising any supervision or control over the practice of medicine, the manner in which medical services are provided, and the administration or operation of medical facilities. The individual is free to obtain health services from any qualified institution, agency, or person that undertakes to provide him such services. Responsibility for the treatment and control of the patient's care remains with the physician, hospital, or other facility or agency furnishing the health services. The law further provides that an individual is free to keep or obtain any other health insurance.

105. FINANCING THE PROGRAM

Part A (Hospital Insurance) is financed through separate payroll contributions paid by employees, employers, and self-employed persons. This is the same method used to finance the social security programs that provide retirement, disability and survivors benefits. Part A tax proceeds are deposited to the account of the Federal Hospital Insurance Trust Funds which may be used only for hospital insurance benefits and administrative expenses. General revenues of the Federal Government are appropriated to pay for Part A benefits furnished individuals who are not social security or railroad retirement beneficiaries.

Part B (Supplementary Medical Insurance) is financed by the monthly premiums of those who voluntarily enroll in the program, matched by an equal contribution from general revenues. All premiums and Government contributions are deposited in a separate account known as the Federal Supplementary Medical Insurance Trust Fund. Money from this fund may be used only to pay for Part B benefits and administrative expenses.

Part B—Supplementary Medical Insurance Benefits for the Aged

110. ELIGIBILITY

An individual who is entitled to Part A benefits or

who is a United States resident, 65 years of age and a citizen, or an alien who has been admitted for permanent residence and has resided in this country for 5 years or more, is eligible to enroll for Part B insurance protection.

States, by agreement with the Secretary of Health, Education, and Welfare, may enroll, and pay premiums, for eligible individuals who are public assistance recipients or medical assistance recipients under certain public or medical assistance programs. Where the State enrolls only money payment recipients, it has the option to exclude persons who are entitled to monthly social security or railroad retirement benefits.

112. ENROLLMENT

A. Enrollment Periods.—Enrollment is possible only during specified enrollment periods.

1. A person's *initial enrollment period* is of 7 months' duration. It begins 3 full calendar months before and ends 3 full calendar months after the month in which the individual first meets all the requirements for enrollment.

2. *General Enrollment Period*.—General enrollment periods afford enrollment opportunities to those who failed to enroll during their initial enrollment periods and to those whose enrollment has terminated. The first general enrollment period was from October 1, 1967 through March 31, 1968. Effective January 1, 1969, there is an annual general enrollment period from January 1 through March 31. Coverage begins the following July 1.

3. *States that desire to enroll eligible individuals receiving assistance* must request coverage before January 1970 and enter into an agreement with the Government.

An individual who fails to enroll for supplementary medical insurance within the 3-year period after the close of his initial enrollment period is precluded from enrolling in the supplementary medical insurance plan.

An individual whose enrollment has terminated may reenroll only once and this must occur in a general enrollment period which begins within 3 years after the termination of his prior enrollment.

B. Beginning of Coverage.—

1. Enrollment during the individual's initial enrollment period—coverage begins:

a. 1st day of the month in which the individual becomes 65, if he enrolls before the month that he becomes 65.

b. 1st day of the month following the month that he becomes 65, if he enrolls in the month that he becomes 65.

c. 1st day of the 2nd month after the month of enrollment, if he enrolls in the month after he became 65.

d. 1st day of the 3rd month after the month of enrollment, if he enrolls more than one month after the month in which he became 65.

2. Enrollment during one of the general enrollment periods—coverage begins the following July 1st.

114. END OF PART B COVERAGE

A. *Voluntary Termination of Part B Coverage*.—Payment may be made for covered services if the individual was enrolled at the time the services were furnished even though the request for payment is filed after enrollment has terminated. Part B coverage terminates when an enrollee dies, or: an individual may notify the Social Security Administration at any time in writing that he wishes to terminate his Part B insurance protection (unless the State is paying his premiums). His insurance will be terminated at the close of the calendar quarter following the calendar quarter in which the notice is filed provided coverage was not terminated earlier for nonpayment of premiums.

B. *Termination of Part B Coverage for Non-Payment of Premiums*.—Part B insurance protection will be terminated because of the nonpayment of premiums. Termination becomes effective at the end of the grace period provided for payment of premiums. (The grace period extends for two calendar months after the month in which the premium is due.)

116. PREMIUMS

The premium rate is \$4.00 a month. The law provides that this rate may be adjusted annually by the Secretary of Health, Education, and Welfare. New premium rates are effective July 1.

The premium rate payable by a person who enrolls after the first enrollment period open to him, or who reenrolls after his initial enrollment was cancelled or terminated, is increased by 10 percent for each 12-month period he could have been but was not enrolled.

Social security or railroad retirement beneficiaries and civil service annuitants (except for those enrolled by a State as assistance recipients) who enroll in Part B will have their premium payments withheld from their monthly checks. The state pays the premiums for the assistance recipients it enrolls.

Other enrollees must make premium payments directly to the Social Security Administration. Generally, persons who must make direct payment will be billed quarterly. However, State or local government agencies, employers, unions, or other organizations such as a GPPP may, under certain conditions, pay premiums for their members as a group.

DISCLOSURE

120. DISCLOSURE OF INFORMATION

Section 1106 of the Social Security Act prohibits disclosure of any file, record, report, or other paper, or any information obtained at any time by the Secretary

or an officer or employee of the Department of Health, Education, and Welfare in the course of discharging his duties under the Act, except as prescribed by regulations. The same prohibition applies to information received from the Secretary or an officer or employee of the Department.

The prohibitions noted apply also to any agency, organization, *e.g.*, a GPPP, or institution, or any of its officers or employees, in the fulfillment of a contract or agreement with the Secretary.

The prohibition also relates to any information received from the Department or a GPPP by any person or entity which furnishes services under arrangements with a provider, or accepts an assignment under the medical insurance program.

The routine medical records of a patient in the possession of a provider or supplier of medical services (other than those obtained from the Social Security Administration) are not bound by the prohibition or by Departmental rules and regulations concerning confidentiality simply because the patient is entitled to benefits under this program. These records, however, may be subject to applicable State or local laws, or hospital rules governing disclosure.

Regulation No. 1 contains the basic authorization for disclosure of information obtained in the administration of the program, from which rules and policies have been developed. The general rule is that information about an individual, organization, institution, etc., obtained in the administration of the program, may not be disclosed without the authorization of the individual, organization, institution, etc., to whom the information relates. Medical information relating to an individual will generally be disclosed under more restrictive conditions than other information and where permitted, usually may be furnished only upon the written authorization of the source of the information as well as the individual. Under this regulation, suppliers of health care services may disclose records or information only when necessary in connection with a claim under the health insurance program and for the proper performance of the duties of any officer or employee of a public or private agency or organization that has entered into an agreement with the Social Security Administration to carry out the provisions of the law and regulations.

Group Practice Prepayment Plans

130. GENERAL INFORMATION

A. Definition.—A GPPP is defined for Medicare purposes as an organization that has a formal arrangement with the equivalent of three or more full-time physicians to provide certain health services, generally on a non-fee-for-service basis, to the plan's members. The members have contributed in advance toward the

cost of the services through the payment of premiums or dues (or such payments have been made on their behalf).

An organization which meets the definition of a GPPP may elect to be reimbursed on a cost basis or on a reasonable charge basis. The former category is referred to as a direct dealing GPPP, while the latter is usually called a carrier dealing GPPP. Under certain conditions, a plan in the latter group may be a direct dealing GPPP. See § 302 for a description of a direct dealing plan which is reimbursed on a reasonable charge basis.

B. Contacts with the Bureau of Health Insurance.—Each GPPP that deals directly with the Social Security Administration is to submit its inquiries about the law, regulations, and general policy or procedures to the Bureau of Health Insurance regional representative in its region. The Bureau has nine regional offices servicing specific geographical areas. Any general questions direct dealing GPPP's have, or any issues or problems that may arise should be referred to the regional office which services the plan's geographical area of operation. (Exhibit 1, § 199, contains a list of the Health Insurance Regional Representatives, their service areas and addresses).

Specific questions concerning procedures or EDP systems should be submitted to the Division of Systems, SSA, Baltimore. Specific questions involving systems, procedures or reimbursement should be referred to the Direct Reimbursement Branch, Division of Reimbursement, BHI, SSA, Baltimore.

Any general questions a carrier-dealing plan may have should be directed to the carrier.

C. Requirements for Disclosure of Information.—

1. Direct dealing GPPP's are required to secure from each member whose name and health insurance claim number is forwarded to the Administration for recordation as a plan member, a statement authorizing the Social Security Administration to furnish to the plan information about his health insurance entitlement and Part B benefits usage. This authorization form is to be retained in the plan files. (See § 380A for a model authorization.) As authorization for release of information should not contain any restrictions on its effective life. If authorizations previously obtained were for a limited period, plans need not undertake a membership contact project for the purpose of securing renewals.

2. The plan must certify to the Administration, at the time it forwards the member's name and number, that the plan has obtained the required authorization from that member and that such authorization is on file. The certification should accompany the shipment of names of enrollees. (See § 384B.)

D. *Handling of Requests to See GPPP Manual.*

—It is expected that plans may occasionally receive requests from the public to examine or obtain copies of the GPPP Manual. Where the plan wishes to make the appropriate material available to the public, it may do so. Where the plan does not wish to do so, it should refer the inquirer to his social security district office.

E. *Handling of Requests to See Other Material.*—Where the plan is requested to reveal material

in its possession other than the manual which has not been authorized for disclosure, the plan should explain that requests should be made to SSA. The individual should make this request in writing and submit this request to the HI regional representative. The request should specify what material is requested and the purpose of the request. The requestor's name, HI claim number if available and appropriate, and address should be clearly shown.

199. EXHIBITS

1. BUREAU OF HEALTH INSURANCE REGIONAL REPRESENTATIVES

<i>REGION</i>	<i>NAME</i>	<i>ADDRESS</i>	<i>PHONE</i>
BOSTON (Conn., Me., Mass., N.H., R.I., Vt.)	Philip J. Gralton, Jr.	John F. Kennedy Federal Building Room 1401 C Boston, Mass. 02203	617-223-6804
NEW YORK (N.J., N.Y., Del.)	Joseph Godfrey	Room 749 26 Federal Plaza New York, N.Y. 10007	212-264-2503
CHARLOTTESVILLE (D.C., Ky., Md., Pa., P.R., Va., V.I., W.Va.)	Jesse L. Lynn	220 Seventh St., N.E. Charlottesville, Virginia 22901	703-296-1452
ATLANTA (Ala., Fla., Ga., Miss., N.C., S.C., Tenn.)	Douglass M. Richard	Room 404 50 Seventh St., N.E. Atlanta, Ga. 30323	404-526-5118
CHICAGO (Ill., Ind., Mich., Ohio, Wisc.)	Fred B. Wolf	Room 712 New Post Office Bldg. 433 W. Van Buren St. Chicago, Ill. 60607	312-353-5585
KANSAS CITY (Iowa, Kans., Minn., Mo., Nebr., N.Dak., S.Dak.)	Warren Robinson	Room 436 601 East 12th St. Kansas City, Mo. 64106	816-374-3539
DALLAS (Ark., La., N.Mex., Okla., Texas)	John M. Mullane	Room 602 1114 Commerce St. Dallas, Texas 75202	214-749-3800
DENVER (Colo., Idaho, Mont., Utah, Wyo.)	Wilburn Smith	Room 557 New Customhouse 721 19 St. Denver, Colo. 80202	303-297-3657
SAN FRANCISCO (Alaska, Ariz., Am. Samoa, Guam, Calif., Hawaii, Nev., Oregon, Wash.)	Mercia L. Kahn (Mrs.)	Room 245 Federal Office Bldg. 50 Fulton St. San Francisco, California 94102	415-556-6561

CHAPTER II

COVERAGE AND LIMITATIONS

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COVERED SERVICES

200. COVERED SERVICES—GENERAL

The supplementary medical insurance plan includes coverage for expenses incurred in connection with:

1. Medical and surgical services by a physician, including consultation, and home, office, or institutional calls. (When the enrollee is not an inpatient of a hospital, the reimbursable expenses for treatment by a medical doctor for mental illness are limited to the lesser of \$312.50 or 62.5 percent of the actual expense in a calendar year.)

2. Services and supplies, including drugs and biologicals which cannot be self-administered, incident to a physician's professional services and of kinds commonly furnished by a physician in his office and which are commonly furnished without charge or included in the physician's bill.

3. Outpatient hospital diagnostic services, effective April 1, 1968.

4. Hospital services incident to a physician's services rendered to outpatients.

5. Diagnostic x-ray (including certain portable x-ray services in the patient's home), laboratory and other diagnostic tests.

6. X-ray, radium, and radioactive isotope therapy (including material and services of technicians).

7. Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations.

8. Rental or purchase of such durable medical equipment as iron lungs, oxygen tents, wheelchairs, and special beds for use in the patient's residence, including an institution used as his home.

9. Ambulance service, where the use of other transportation is contraindicated by the patient's condition, and the patient is taken to a hospital within his locale which is equipped to take care of him.

10. Prosthetic devices, other than dental, replacing all or part of an internal body organ (including contiguous tissue), or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ, and replacements or repairs of such devices.

11. Leg, arm, back, and neck braces; artificial legs, arms, and eyes; including replacements if required because of a change in physical condition.

12. Outpatient physical therapy services furnished by participating hospitals, extended care facilities, home health agencies, clinics, rehabilitation agencies, and public health agencies or by others under arrangements with and under the supervision of such organizations. This provision was effective with services furnished on or after July 1, 1968.

13. Home health services for up to 100 visits during a calendar year. This is in addition to the home health

services covered under the Part A program. There is no prior inpatient stay requirement for home health services under Part B as there is under Part A. If the patient is entitled to have payment made under Part A, he must use up all the Part A home health services entitlement before home health services under Part B can begin.

Payment for covered medical insurance services rendered to beneficiaries by providers of services (i.e., hospitals, extended care facilities, home health agencies and outpatient physical therapy providers) may be made only to the provider. Providers furnishing such medical and other health services will generally be reimbursed by the hospital insurance (Part A) intermediary. See § 322 for reimbursement of provider services furnished in a GPPP's own provider facility or furnished by arrangement with a GPPP.

202. PHYSICIANS' SERVICES

Physicians' services mean the professional services performed by a physician or physicians for a patient including diagnosis, therapy, surgery, and consultation. The services must be rendered by the physician. However, services by means of a telephone call between physicians and beneficiaries (including those in which the physician provides advice or instructions to or on behalf of a beneficiary) are not covered services.

It is immaterial where the professional services of the physician are performed as long as they are provided within the United States. They may be performed in the course of a home, office, or institutional call. A patient's home is anywhere that he makes his residence, e.g., a home for the aged, a nursing home, a relative's home, and so forth. If a physician renders professional services at the scene of an accident, these services are included.

A consultation is reimbursable when it is a professional service furnished a patient by a second physician or consultant at the request of the attending physician. Such a consultation includes the history and examination of the patient as well as the written report.

202.1 Definition of Physician.—Physician means a doctor of medicine, osteopathy (including osteopathic practitioner), or effective January 1, 1968, podiatry, legally authorized to practice by a State in which he performs this function. A doctor of dental surgery or dental medicine having State authorization to practice is also a "physician," but only with respect to surgery related to the jaw or any structure contiguous to the jaw, or the reduction of any fracture of the jaw or any facial bone.

The services performed by a physician within these definitions are subject to any limitations imposed by the State on the scope of practice.

In all States, the issuance by the State of a license to practice medicine constitutes legal authorization. Temporary State licenses also constitute legal authorization to practice medicine. If State law authorizes local political subdivisions to establish higher standards for medical practitioners than those set by the State licensing board, such local standards will be used in determining whether a particular physician has legal authorization. If State licensing law limits the scope of practice of a particular type of medical practitioner, only the services within these limitations will be covered.

NOTE: The term "physician" does not include a Christian Science practitioner, chiropractor, naturopath, optometrist or other such practitioners.

202.2 Doctors of Medicine and Osteopathy.—The requirement that a doctor of medicine must be legally authorized to practice medicine and surgery by the State in which he performs his services means a physician who is licensed to practice medicine and surgery.

A doctor of osteopathy who is legally authorized to practice medicine and surgery by the State in which he performs his services qualifies as a physician. In addition, a licensed osteopath or osteopathic practitioner qualifies as a "physician" to the extent that he performs services within the scope of his practice as defined by State law. For example, in some States osteopaths and osteopathic practitioners are limited in their practice to the manipulation of bones and muscles; such legally authorized services are covered.

202.3 Podiatrists.—Podiatrists (chiroprodists) are included effective January 1, 1968 within the definition of "physician" but only with respect to those functions which they are legally authorized to perform in the State in which they perform them. This means that the professional services provided by a podiatrist within the scope of his applicable State license (except those services which are specifically excluded, see § 232), are "physicians' services," reimbursable on a reasonable charge basis under Part B. Services and supplies incident to a podiatrist's services are covered if they are incident to covered professional services.

Podiatrists may hold any of the following professional degrees, of which the first three are the most common: Pod.D. or D.P. (Doctor of Podiatry), D.S.C. (Doctor of Surgical Chiropody), D.P.M. (Doctor of Podiatric Medicine), D.S.P. (Doctor of Surgical Podiatry), Graduate in Podiatry, Master Chiropodist, Graduate Chiropodist, or in a very few instances another podiatry degree. Within a particular State all individuals holding any of these degrees are licensed to perform the same functions; however, there are variations from State to State as to the authorized scope of podiatric practice.

202.4 Dentists.—A dentist may qualify as a "physician" under Medicare if he is a doctor of dental surgery or dental medicine legally authorized to practice dentistry by the State in which he performs his services. However, because of the general exclusion of payment for dental services, payment for the services of dentists is limited to those surgical procedures which do not involve the teeth or structures directly supporting teeth. (§§ 220 and 237 also concern this exclusion.) The coverage or exclusion of any given dental service is not affected by the professional designation of the "physician" rendering the services, i.e., an excluded dental service remains excluded and a covered dental service is still covered whether furnished by a dentist or a doctor of medicine.

202.5 Hospital-Based Physicians' Services.—The services of hospital based physicians (e.g., those on a salary, or percentage arrangement, lessors of departments, etc., whether or not they bill patients directly) include two distinct elements, the professional component and the provider component. (The services of interns and residents are reimbursable to the provider on a reasonable cost basis even though the intern or resident is a licensed physician.) See § 310.1.

A. The Professional Component.—The professional component of hospital-based physicians' services includes those services directly related to the medical care of the individual patient. (No Part B charge can be recognized for autopsy services.) Services to individual patients must be specially billed by the physician or, with his authorization, by the provider. Reimbursement is ordinarily made for these services on a reasonable charge basis by the supplementary medical insurance (Part B) intermediary.

Group Practice Prepayment Plans which deal directly with the Social Security Administration may make a written agreement with a hospital, or with physicians in a hospital, to reimburse the professional component of the hospital-based physician's charge for services to plan members entitled to Part B. See § 310.1 for reimbursement of these services.

B The Provider Component.—Provider-based physicians often perform professional services other than those directly related to the medical care of individual patients. These may involve teaching, administrative, and autopsy services, and other services that benefit the provider's patients as a group. Such physician services, not directly related to an individual patient, if compensated, are considered in computing reimbursable provider costs. Reimbursement for such costs is made under Part A where they relate to inpatient services and under Part B where outpatient services are involved.

202.6 Interns and Residents.—Services performed by interns and residents—including physicians

employed by a hospital who are authorized to practice only in a hospital setting—are reimbursable to the provider on a reasonable cost basis by the Part A intermediary even if the intern or resident is also a licensed physician. Certain of these services, when performed by interns and residents under approved training programs, are covered under Part A. Services of interns and residents which are covered under Part B, *but are not reimbursable on a reasonable charge basis even though such persons are physicians legally authorized to practice*, include:

A. The medical and surgical services performed for hospital inpatients by interns and residents who are not under approved teaching programs,

B. The medical and surgical services performed in hospital outpatient departments by interns and residents regardless of whether they are under an approved teaching program.

C. The medical and surgical services performed for hospital, extended care facility and home health agency patients by interns and residents (whether or not under an approved program) which are not covered under Part A, e.g., the beneficiary has exhausted his allowed days of inpatient hospital or extended care facility coverage under Part A (or has elected not to use his lifetime reserve hospital days) in his current spell of illness.

All services of an intern or resident not under an approved training program (including an intern or resident in podiatry) whether or not he is fully authorized to practice, are Part B provider services when performed in a provider setting. Thus, when a resident performs services in addition to the usual services he provides under his training program, whether they are for the hospital at which he is receiving his training or at another hospital, they are reimbursable on a cost basis under Part B. Providers bill for these services just as they would for usual services of interns and residents not under an approved training program.

202.7 Radiological and Pathological Services to Hospital Inpatients.—Effective April 1, 1968, reimbursement may be made under Part B for the *full* reasonable charge for radiological and pathological services furnished to inpatients of a *qualified* hospital (i.e., one that meets all of the conditions of Medicare participation) by a physician in the field of radiology or pathology. This means that 100 percent reimbursement will be made for the reasonable charges for such services, subject to neither the usual deductible nor coinsurance features of Part B. Expenses incurred under this provision do not count toward the \$50 Part B deductible. See § 310.1 for separate cost recording by direct-dealing plans.

A. Definition of Radiological and Pathological Services.—The term “radiological services” means services in which x-rays or rays from radioactive substances are used for diagnostic or therapeutic purposes. Such services include but are not limited to radium therapy, the use of radioisotopes for diagnostic or therapeutic purposes (as in nuclear medicine), and diagnostic tests such as angiograms, aortograms, pyelograms, myelograms, arteriograms, ventriculograms, etc.

The term “pathological services” refers to services performed in both clinical and anatomical pathology. Included are microbiological, serological, chemical, hematological, biophysical, cytological, immunohematological, and pathological examinations performed on material derived from the human body, to provide information for the diagnosis, prevention, or treatment of a disease or assessment of a medical condition.

Such tests as BMR’s, EEG’s, and EKG’s are considered to be neither radiological nor pathological services. Therefore, reimbursement for such tests can be made only at the 80 percent rate, after recognition of the deductible, and the combined billing method may not be used for such services rendered to hospital inpatients.

NOTE: Reimbursement can be made at the 100 percent rate for only those radiological and pathological services performed by physicians in the fields of radiology and pathology.

B. Field of Radiology or Pathology.—A physician in the “field of radiology or pathology” includes not only a specialist in one of those fields, i.e., a radiologist or a pathologist, but also a physician who normally performs or supervises the radiological or pathological services for patients of a particular hospital, even though the physician does not otherwise specialize in radiology or pathology. An example of this situation is a small hospital that has no radiologist but designates another physician to handle or supervise the hospital radiological procedures. The full reasonable charge for the radiological services of this physician rendered in such a capacity would be covered. On the other hand, the reading of an x-ray film as part of his usual services for his own patients by, for example, an attending physician or a surgeon would normally be covered only as regular physicians’ services, i.e., the basis for reimbursement would be 80 per cent of the reasonable charge, subject to the \$50 deductible.

204. SERVICES AND SUPPLIES

Services and supplies (including drugs and biologicals which cannot be self-administered) are those furnished incident to a physician’s professional service, of kinds which are commonly furnished in physicians’ offices or clinics and are commonly either rendered without charge or included in physicians’ bills. (Cer-

tain hospital services are also covered as incident to physician services when rendered to outpatients. These services are reimbursed to the hospital on a reasonable cost basis by the Part A intermediary.)

"Incident to a physician's professional service" means that the services are administered as part of the physician's professional services in the course of diagnosis or treatment of an injury or illness.

A. Services and Supplies Commonly Furnished in Physicians' Offices.—Coverage of services and supplies incident to the professional services of a physician in private practice is limited to situations in which there is direct physician supervision. This applies to services of auxiliary personnel employed by the physician and working under his supervision, such as nurses, non-physician anesthetists, psychologists, technicians, therapists, including physical therapists, and other aides. For example, if a physician employs a physical therapist and includes the charges for such services in his own bills, the services of the physical therapist are considered to be incident to the physician's services if there is direct personal supervision by the physician.

Similarly, the services of a nonphysician anesthetist are covered under medical insurance when the anesthetist is the employee of an anesthesiologist who provides direct, personal, and continuous supervision. Direct, personal, and continuous supervision does not require the anesthesiologist to be in the operating room at all times. However, he must be close by and available to provide immediate and personal assistance and direction. Availability of the anesthesiologist by telephone would not constitute direct, personal, and continuous supervision. The services of a nonphysician anesthetist are also covered when he is an employee (either on a part- or full-time basis) of any surgeon (or other physician) who is directing and rendering professional services during the operative procedure. In both cases, the physician must include the charges in his bill for the anesthetist's services and these charges will be taken into account in determining the physician's reasonable charge.

If auxiliary personnel perform services outside the office setting, the services are covered only if there is direct personal supervision by the physician. For example, if a nurse accompanied a physician on house calls and administered an injection, the nurse's services are covered; if the same nurse made the calls alone and administered the injection, the services are not covered (even when billed by the physician) since a physician would not be providing direct personal supervision.

Services provided by auxiliary personnel not in the employ of a physician, even if provided on the physician's order or included in the physician's bill are not covered (e.g., an independently practicing therapist who forwards his bill to the referring physician for

inclusion in the physician's statement of services) since the law requires that the services be of kinds commonly furnished in physicians' offices and commonly either rendered without charge or included in physicians' bills. As with the physician's personal professional services, the patient's financial liability for the incidental services is to the physician; therefore, the incidental services must represent an expense incurred by the physician in his professional practice.

Supplies usually furnished by a physician in the course of performing his services, such as gauze, ointments, bandages, oxygen, cardiac pacemakers, etc., are also covered. Payment for drugs and biologicals which cannot be self-administered can be made only for the charges of the physician who administers them or supervises their administration. For example, in the case of an allergist who prepares drugs for a patient, no payment can be made for the drugs unless the allergist also administers them. The services of another physician in administering such drugs would, of course, be covered. Charges for such services and supplies must be included in the physicians' bills.

B. Services and Supplies Incident to a Physician's Service in a Clinic.—Services and supplies incident to a physician's service in a physician-directed clinic or group association are generally the same as those described in A. above. However, in highly organized clinics, particularly those which are departmentalized, "direct personal physician supervision" may be the responsibility of several physicians (as opposed to an individual attending physician). In this situation, medical management of all services provided in the clinic is assured. The physician ordering a particular service need not be the physician who is supervising the service. Therefore, services performed by therapists and other aides are covered even though performed in another department of the clinic. Supplies provided by the clinic during the course of treatment are also covered.

When auxiliary personnel perform services outside the clinic premises, the services are covered only if performed under the direct personal supervision of a clinic physician. If the clinic refers a patient for auxiliary services performed by personnel who are not employed by the clinic, such services would not be incident to a physician's service.

204.1 Drugs and Biologicals.—Drugs and biologicals are covered only if of the type that cannot be self-administered and are generally limited to those that are administered by injection. Thus, injections would be covered even if required on a continuing basis, such as those for pernicious anemia, arthritis, etc., provided they are administered by the physician or his nurse. However, if the injection is of the type which is commonly self-administered, such as insulin,

the drug or biological is excluded unless administered to the patient in an emergency situation, e.g., diabetic coma. Charges for the physician services may be covered even though the injection itself may not be covered.

Whole blood or packed red cells is a biological which cannot be self-administered and is covered only when furnished incident to a physician's service. (See § 249 for deductible provision.)

Prescription and nonprescription drugs and biologicals purchased by or dispensed to a patient are *not covered*.

Vaccinations or inoculations are covered if directly related to treatment of an injury or direct exposure such as antirabies treatment, tetanus antitoxin, or booster vaccine, botulin antitoxin, antivenin, or immune globulin. On the other hand, immunization (vaccinations or inoculations) against such diseases as smallpox, polio, diphtheria, etc., are *not covered*.

Within the above limitations "*drugs and biologicals*" mean those included or approved for inclusion in the latest official edition of the United States Pharmacopoeia, the National Formulary, the United States Homeopathic Pharmacopoeia, or New Drugs or Accepted Dental Remedies (except those unfavorably evaluated). Combination drugs are also included in the definition of drugs if the combination itself or all of the therapeutic ingredients of the combination are included or approved for inclusion in any of the above drug compendia.

The exclusion from coverage of drugs and biologicals unfavorably evaluated in New Drugs and in Accepted Dental Remedies applies to those drugs and biologicals which have been unfavorably evaluated for all medicinal uses. If a drug or biological has been unfavorably evaluated for one or more, *but not all*, medicinal uses, the exclusion applies only where the drug has been unfavorably evaluated for the medicinal use to which it is being put.

Drugs and biologicals are considered "approved for inclusion" in a compendium if approved under the established procedure by the professional organization responsible for revision of the compendium.

206. DIAGNOSTIC X-RAY, DIAGNOSTIC LABORATORY, AND OTHER DIAGNOSTIC TESTS

Diagnostic x-ray, laboratory, and other diagnostic tests, including materials and the services of technicians are covered. Some examples of other diagnostic tests are basal metabolism readings, electroencephalograms, electrocardiograms, respiratory function tests, cardiac evaluations, allergy, otologic evaluations, and psychological tests. In the case of diagnostic x-ray services and other diagnostic tests (except as provided

in §§ 206.1A, 206.3 and 206.4), payment may be made only if the services are furnished by a physician (and as incident to a physician's services).

206.1 Coverage of Portable X-Ray Services Not Under the Direct Supervision of a Physician.—

A. *Diagnostic X-Ray Tests.*—Effective January 1, 1968, diagnostic x-ray services furnished by a portable x-ray supplier are covered under medical insurance when furnished in a place of residence used as the patient's home and in nonparticipating institutions, where the services are performed under the general supervision of a physician and certain conditions relating to health and safety are met.

Effective April 1, 1968, diagnostic portable x-ray services are covered under medical insurance in participating ECF's and hospitals when these services cannot be covered under hospital insurance, e.g., the patient is not entitled to Part A benefits.

B. *Applicability of Health and Safety Standards.*—The health and safety standards apply to all suppliers of portable x-ray services except participating hospitals and extended care facilities and physicians who provide immediate personal supervision during the taking of such tests.

C. *Scope of the Portable X-Ray Benefit.*—In order to avoid providing reimbursement for services which are inadequate or hazardous to the patient, the scope of the covered portable x-ray benefit is defined as:

- (1) skeletal films involving the extremities (i.e., arms and legs), pelvis, vertebral column, and skull;
- (2) chest films which do not involve the use of contrast media (except, of course, routine screening procedures and tests in connection with routine physician examinations);
- (3) abdominal films which do not involve the use of contrast media.

206.2 Diagnostic laboratory services furnished by an independent laboratory are covered under medical insurance if the laboratory is an approved *Independent Clinical Laboratory*. (See §§ 310 and 419 for independent laboratory services as a GPPP-arranged service.)

A. *An independent laboratory* is one which is independent both of the attending or consulting physician's office and of a participating Medicare hospital or a non-participating hospital that meets at least the requirements for coverage of emergency services. A consulting physician, as distinguished from one providing clinical laboratory services, is defined as one whose services include history taking, examination of the patient and, in each case, furnishing to the attending physician an opinion concerning diagnosis or treatment. A laboratory which is operated by or under the supervision of a hospital which does not meet at least

the definition of an emergency hospital or of the organized medical staff of such a hospital is considered to be an independent laboratory. The laboratory which a physician or a group of physicians maintains for performing diagnostic tests in connection with his own or the group practice would not be considered an "independent laboratory."

An out-of-hospital laboratory is ordinarily presumed to be independent unless there is written evidence establishing that it is operated by or under the supervision of a hospital which meets the conditions of participation or of the organized medical staff of such a hospital. A laboratory which serves the hospital patients and is operated on the premises of a hospital which meets the conditions of participation is considered to be subject to the oversight of the hospital or its organized medical staff and hence, for purposes of application of the appropriate licensure and health and safety standards under the law is not an independent laboratory.

B. *A clinical laboratory* is a laboratory where microbiological, serological, chemical, hematological, biophysical, cytological, immunohematological, or pathological examinations are performed on materials derived from the human body, to provide information for the diagnosis, prevention, or treatment of a disease or assessment of a medical condition.

C. *An approved independent clinical laboratory* is one which is approved by the Secretary of Health, Education, and Welfare as meeting the specified conditions for coverage under the program. These require that: (1) where State or applicable local law provides for licensing of independent clinical laboratories, the laboratory is either licensed under such law or is approved as meeting the requirements for licensing laboratories; and (2) such laboratories meet the health and safety requirements prescribed by the Secretary of Health, Education, and Welfare.

206.3 Psychologists Practicing Independently.

—The diagnostic services performed by a qualified psychologist practicing independently of an institution, GPPP, agency, or physician's office are covered as "other diagnostic tests" if a physician orders such testing. A qualified psychologist is an individual who, if practicing in a State where statutory licensure or certification exists, holds a valid credential (as legally specified) for such practice. If practicing elsewhere, the psychologist must: (a) hold a doctoral degree in clinical psychology from an American Psychological Association approved program in clinical psychology or adjudged equivalent; or (b) have attained recognition of competency through the American Board of Examinations for Professional Psychology or through endorsement by his State psychological association.

NOTE: There is no provision for coverage of psy-

chotherapy performed by privately practicing psychologists.

Reimbursement for diagnostic psychological services performed by qualified independent psychologists will be made on the basis of the reasonable charge. Expenses for such testing are not subject to the payment limitations on treatment for mental, psychoneurotic, and personality disorders. (§ 255.)

206.4 Otologic Evaluations.—Diagnostic testing performed by a qualified audiologist is covered as "other diagnostic tests" when a physician orders such testing for the purpose of obtaining additional information necessary for his evaluation of the need for or appropriate type of medical or surgical treatment for a hearing deficit or a related medical problem. For example, diagnostic services performed by a qualified audiologist to measure a hearing deficit or to identify the factors responsible for the deficit are covered where such services are necessary to enable the physician to determine whether otologic surgery is indicated. However, where the medical factors required to determine the appropriate medical or surgical treatment are already known by the physician or are not under consideration and the diagnostic services are performed only to determine the need for or the appropriate type of a hearing aid, the services are excluded whether performed by a physician or non-physician.

Diagnostic services which meet the above requirements are covered as "other diagnostic tests" when performed by a qualified audiologist who is either independently practicing or on the staff of a clinic which is not physician-directed.

A qualified audiologist is an individual who, if practicing in a State where statutory licensure or certification exists, holds a valid credential (as legally specified) for such practice and who meets one of the following requirements:

(1) has been granted a Certificate of Clinical Competence in the appropriate area (audiology) by the American Speech and Hearing Association; or

(2) has completed the academic and practicum requirements for certification and is in the process of accumulating the necessary supervised work experience required for certification; or

(3) until January 1, 1970, has a Basic Certificate or provisional basic certification and is in the process of acquiring four years of sponsored professional experience; or

(4) had a Basic Certificate or sponsor privilege as of December 31, 1964, cannot complete four years of sponsored professional experience before January 1, 1970, but passes a special examination given by the American Speech and Hearing Association during 1969.

NOTE: There is no provision for coverage of therapeutic services performed by privately practicing audiologists or audiologists on the staff of a clinic which is not physician-directed.

208. X-RAY, RADIUM, AND RADIOACTIVE ISOTOPE THERAPY

These services also include materials and services of technicians.

210. SURGICAL DRESSINGS, AND SPLINTS CASTS, AND OTHER DEVICES USED FOR REDUCTION OF FRACTURES AND DISLOCATIONS

Surgical dressings include therapeutic and protective covering for lesions either on the skin or opening to the skin required as the result of a surgical procedure performed by a physician. Surgical dressings are usually applied first by a physician and are covered under Part B as incident to a physician's professional service (§ 204). However, dressings may be reapplied by others including the patient or a member of his family. When *surgical* dressings are obtained by the patient on a physician's order from a supplier, e.g., a drugstore, the surgical dressing is covered under Part B. Dressings required for purposes other than a surgical lesion, e.g., bedsores, are not covered. A colostomy bag and necessary accoutrements required for its attachment are covered as a surgical dressing. However, irrigation equipment and supplies used in treating a colostomy condition are not covered under this section. Splints and casts, etc., include dental splints.

212. RENTAL OR PURCHASE OF DURABLE MEDICAL EQUIPMENT

Expenses incurred by a beneficiary for the rental or, effective January 1, 1968, purchase of equipment for use in his home are covered if the equipment meets the definition of durable medical equipment. In addition, reimbursement can be made only so long as the equipment in a specific case is reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member.

A beneficiary may elect to rent an item of equipment rather than purchase it even though it may appear that purchase would be more economical for the program. The decision as to whether an item of equipment will be rented or purchased is made by the beneficiary.

212.1 Definition of Beneficiary's Home.—For purposes of rental or purchase of durable medical equipment, a beneficiary's home may be his own dwelling, an apartment, a relative's home, or a home for the aged or some other type of institution. However,

an institution may not be considered a beneficiary's home if it:

1. Meets at least the basic requirement in the definition of a hospital, i.e., it is primarily engaged in *providing by or under the supervision of physicians*, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, and sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons (section 1861(e) (1) of the law), or

2. Meets at least the basic requirement in the definition of an extended care facility, i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons (section 1861(j) (1) of the law).

Thus, if an individual is a patient in an institution or distinct part of an institution which provides the services described in 1 or 2 above, he is not entitled to have payment made for rental or purchase of durable medical equipment since such an institution may not be considered his home.

212.2 Definition of Durable Medical Equipment.—Durable medical equipment is equipment which (1) can withstand repeated use, and (2) is primarily and customarily used to serve a medical purpose, and (3) generally is not useful to a person in the absence of illness or injury.

All of the above elements of the definition of durable medical equipment must be evaluated in determining whether equipment is covered. For example, a price of equipment might meet the requirements that it withstand repeated use and have some usefulness from a medical standpoint; however, it would not be covered if it would also generally be useful to individuals in the absence of an illness or injury. Iron lungs, intermittent positive pressure breathing machines, oxygen tents, etc., are examples of equipment primarily and customarily used for medical purposes.

However, certain types of equipment which are primarily and customarily used for medical purposes, are also of considerable use to persons who are not ill or injured. Such equipment will be covered only when it contributes meaningfully to the treatment of an illness or injury or the functioning of a malformed body member. Heat lamps, for example, would fall into this category.

Equipment which is primarily and customarily used for a nonmedical purpose may not be considered "medical" equipment for which payment can be made under the medical insurance program. This is true even though the item has some remote medically related use. For example, in the case of a cardiac patient,

an air conditioner might possibly be used to lower room temperature to reduce fluid loss in the patient and to restore an environment conducive to maintenance of the proper fluid balance. Nevertheless, because the primary and customary use of an air conditioner is a nonmedical one, the air conditioner *cannot* be deemed to be medical equipment for which Medicare payment can be made.

Similarly, other devices and equipment used for environmental control or to enhance the environmental setting in which the beneficiary is placed are not considered covered durable medical equipment. These include, for example, heating plants, cooling plants, humidifiers, dehumidifiers, as well as elevators, stairway elevators, and other equipment which basically serve comfort or convenience functions or are primarily for the convenience of a person caring for the patient. Equipment used solely for the prevention of illness or injury is not covered.

Although the law specifically mentions iron lungs, oxygen tents, hospital beds, and wheelchairs as examples of durable medical equipment, there is a wide and diverse range of items which can be so classified. Illustrative of this range of covered items are walkers, inhalators, nebulizers, commodes, suction machines, traction equipment, crutches, canes, trapeze bars, respirators, intermittent positive pressure breathing machines, and other breathing equipment. Each of these items has many varied types for specialized use. For example, there are types of wheelchairs specially designed for amputees, for partially paralyzed patients, for patients with fractured extremities, for obese patients, electric powered chairs, etc. In the specific case, the patient's illness or injury must be considered in resolving coverage issues.

Medical supplies such as incontinent pads, lamb's wool pads, catheters, ace bandages, elastic stockings, and goods of an expendable nature, such as face masks, irrigating kits, disposable sheaths and bags are not considered "durable" within the meaning of the above definition. These and other items which constitute medical supplies, or fall into other categories such as surgical dressings, braces, prostheses, splints, casts, artificial arms, legs, and eyes do not come under the specific provision in the law relating to the coverage of durable medical equipment.

212.3 Medical Necessity for the Equipment.—

A. Initial Determination of Medical Necessity.—Although an item may be classified as durable medical equipment, its rental or purchase is not necessarily covered in every instance. Coverage in a particular case is subject to the requirement that the equipment is reasonable and necessary for diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. These considerations will

generally bar payment for the "deluxe" or "luxury" model of the durable medical equipment if the standard model would be adequate. For example, payment would not be made for a motorized wheelchair if a nonmotorized chair would meet the patients' medical needs. A motorized wheelchair would be covered, however, in a case where the patient does not have use of his arms (e.g., a stroke case) or in arm or hand amputation cases. In most other cases a motorized wheelchair would be a convenience item.

If a claim is made for rental or purchase of deluxe equipment when a standard model would serve the intended medical purpose, payment will be made based upon the reasonable charge for the standard model.

B. Determining the Period of Medical Necessity.—

1. General Rule.—Generally, the period of time an item of durable medical equipment will be considered to be medically necessary is based on the physician's estimate of the time that his patient will need the equipment. Physicians, therefore, are required to show the estimated period (in months) on the prescription given the beneficiary or the supplier of the equipment (in both rental and purchase situations).

2. "Indefinite" Period of Medical Necessity.—When the physician estimates that the patient will need an item of durable medical equipment "indefinitely" or the period of medical necessity will be more than 6 months, a reevaluation of medical necessity will be made not later than the sixth month that periodic payments for purchase or reimbursement for rental is made.

212.4 Methods of Payment.—

A. Rental.—When equipment is rented, payment is based on the reasonable rental charge. This charge is determined by the customary charge of the supplier and the prevailing charge in the locality.

B. Purchase.—In the case of purchase of durable medical equipment (except in certain circumstances where "inexpensive equipment" is purchased), payment will be made in amounts equivalent to payments that would have been made had such equipment been rented. Such equivalent payments may be made over the period of time the equipment is determined to be medically necessary for the individual's care and treatment or until the total of the monthly installments equals the reasonable purchase price, whichever comes first. For purchases of "inexpensive equipment" payment may be made in a lump sum if that method of payment is less costly or more practical than periodic payments. For purposes of these provisions "inexpensive equipment" is any item of durable medical equipment for which the reasonable charge is \$50 or less.

1. Lump-sum Payment for Inexpensive Equipment.—Payment for inexpensive equipment which a

beneficiary purchases will be made in a lump sum (subject to deductible and coinsurance provisions) when it is determined to be *less costly* or *more practical* to do so. As a general rule, the presumption is that it would be less costly or more practical to make a lump-sum payment for inexpensive equipment (reasonable charge of \$50 or less). However, an exception to this rule may be made where the estimated period of time that the equipment will be medically necessary for the care and treatment of the beneficiary is relatively short, e.g., 1 or 2 months. Assume, for example, that a walkerette (purchase price \$47.50) rents for \$5 a month. If the physician estimated that the walkerette would be needed for only 2 months, it would be considered less costly to make a payment equivalent to the two periodic payments than to pay a lump-sum amount based on the reasonable purchase price. However, the total of the periodic payments as indicated by the estimate will be paid at the time of initial adjudication of the claim.

2. Periodic Payments for Expensive Equipment.—Where it is concluded that a lump sum cannot be paid in accordance with the guidelines in 1. above, reimbursement will be made in monthly installments equivalent to the payments that would have been made had the beneficiary chosen to rent the equipment. Benefits, however, can be paid only for that period of time during which medical necessity for the equipment has been established or until the total of the monthly installments equals the reasonable purchase price, whichever comes first. While periodic payments will be made on a monthly basis, a single payment can be made for periodic payments that have accrued. The periodic payments are subject to the deductible and coinsurance provisions.

The number of periodic payments that may be made in order to equal the reasonable purchase price is determined by dividing the reasonable purchase price (plus any State or local taxes) by the reasonable monthly rental charge. If the remainder is one-half or more, an additional periodic payment will be made; if it is less than one-half, the remaining reimbursement may be added to the last full periodic payment.

A new claim will not be needed for each periodic payment.

3. When Periodic Payment Expenses are Incurred.—The first month's expense for rental of durable medical equipment is incurred as of the date of delivery of the equipment for purposes of crediting the Part B deductible and for reimbursement. Expenses for subsequent months are incurred on the same day of the month as the day of delivery.

Example: In 8/69, Mr. Thomas, a paraplegic, signed an agreement to purchase a wheelchair for \$200. The wheelchair was delivered to him on 9/8/69, and he immediately submitted his claim and an item-

ized bill to the carrier. The reasonable rental charge is \$20 a month. Since he did not have any other covered Part B expenses during the year, periodic payments for 9/69, 10/69, and half of the payment for 11/69 are withheld to satisfy the deductible. The first reimbursement would become payable on 11/8/69. Since \$30 of the deductible was met in the last quarter of 1969, payment for 1/70 would also be withheld to satisfy the deductible for 1970.

212.5 Payment for Repairs, Supplies (Including Oxygen) and Non Re-usable Accessories.—

A. Payment for Repairs.—Reasonable repairs to durable medical equipment already owned by the beneficiary are covered. Generally, repairs would be considered reasonable where (1) they are limited to making the equipment serviceable, and (2) the cost to make the equipment serviceable for the estimated period of need is less than the estimated cost of rental or purchase of another unit.

B. Oxygen and Non Re-usable Supplies.—Reimbursement may be made for oxygen, hoses, tubes and other non re-usable supplies that are essential to the effective use of a medically necessary item of durable medical equipment, whether the equipment is rented or purchased. Payment can also be made for such items and supplies following the period when periodic payments have been completed provided that there is a continuing medical necessity for the equipment. Where the beneficiary purchased the equipment prior to January 1, 1968, it must be established that medical necessity for the equipment continues to exist and that the oxygen or other supply is required for the effective use of the equipment.

C. Medications.—Medications which may be used in connection with durable medical equipment are not covered. The medications fall within the drug restriction and are, therefore, not covered under Part B except for those which cannot be self-administered and are provided as incident to a physician's professional services. Also, no payment can be made under this provision for any items or supplies where the use of durable medical equipment is not involved.

212.6 Miscellaneous Issues Included in Purchase and Rental of Equipment.—Payment can be made for the purchase of durable medical equipment even though rental payments may have been made for prior months. This could occur where, because of a change in the beneficiary's condition, purchase becomes advantageous.

A beneficiary may sell or otherwise dispose of equipment for which he has no further use, for example, because of recovery from the illness or injury which gave rise to the need for the equipment. (There is no authority for the program to repossess equip-

ment.) If after such disposal there is again medical need for similar equipment, payment can be made for the rental or purchase of that equipment.

214. AMBULANCE SERVICE

An ambulance is a specially designed or equipped automobile or other vehicle (in some areas of the United States this might be a boat or plane) for transporting the sick or injured. It must have customary patient care equipment including a stretcher, clean linens, first aid supplies, oxygen equipment, and any safety and lifesaving equipment required by State or local authorities.

Personnel whose duties involve the care or handling of the patient while providing ambulance service must have adequate training in the application of first aid, i.e., training which is at least equivalent to the training provided by the standard and advanced Red Cross first aid courses. The driver does not have to meet the first aid training requirement if there is at least one other person assigned to the ambulance who has had the required training. Training "equivalent" to the standard and advanced Red Cross first aid training courses includes ambulance service training and experience acquired in military service, successful completion by the individual of a comparable first aid course furnished by or under the sponsorship of State or local authorities, an educational institution, a fire department, a hospital, a professional organization, or other such qualified organization. On-the-job training involving the administration of first aid under the supervision of or in conjunction with trained first aid personnel for a period of time sufficient to assure the trainee's proficiency in handling the wide range of patient care services that may have to be performed by a qualified attendant can also be considered as "equivalent training."

A. *For coverage of ambulance services*, each of the following three conditions must be met.

1. The vehicle used to provide the ambulance service and the ambulance personnel whose duties involve care of the patient meet the requirements specified above.

2. Ambulance service is covered only where the use of any other method of transportation is medically contraindicated by the patient's condition. (In any case in which some means of transportation other than an ambulance could be used without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance service.)

3. As a general rule, only local transportation by ambulance is covered. This means that the patient must have been transported to an institution (i.e., a hospital or a skilled nursing facility) whose locality encom-

passes the place where the ambulance transportation of the patient began and which would ordinarily be expected to have available the needed institutional services for the treatment of the injury or illness involved. In exceptional situations where the ambulance transportation originates beyond the locality of the institution to which the beneficiary was transported, payment may be made for such service *only* if the evidence clearly establishes that such institution is *the nearest one with appropriate facilities*. The hospital or skilled nursing facility to which a patient is transported need not be a participating institution.

Ambulance service from an institution to the beneficiary's *home* is covered when his home is within the locality of the institution from which he was being transported or where the beneficiary's home is outside of the locality of the institution and the institution in relation to his home is the nearest one with appropriate facilities.

There are instances where the institution to which the patient is initially taken is found to have inadequate facilities for treating him and he is then transported to a second institution having appropriate facilities. In such cases, transportation by ambulance to both institutions would be covered provided the institution to which he is being transferred is determined to be the *nearest* one with appropriate facilities. In these cases, transportation from such second institution to the patient's home could be covered if his home is in the locality serviced by that institution or by the first institution to which he was taken.

The above requirement is intended to provide coverage of essential ambulance service without imposing an arbitrary "mileage" limitation. It is not contemplated, however, that payment would be made for ambulance services that involve transporting the patient beyond the locality except where he is transported to the nearest institution with appropriate facilities. In any other case, where the ambulance transportation began beyond the locality of the institution to which the patient was transported, *no part* of the ambulance trip is covered.

a. *Locality*.—The term "*locality*," with respect to ambulance service, means the service area surrounding the institution from which individuals normally come or are expected to come for hospital or skilled nursing facility services.

EXAMPLE: Mr. A. becomes ill at home and requires ambulance service to the hospital. The small community in which he lives has a 35-bed hospital. Two large metropolitan hospitals are located some distance from Mr. A's community but they regularly provide hospital services to the community's residents. The community is within the "*locality*" of the metropolitan hospitals and direct ambulance service to either

of these (as well as to the local community hospital) is covered.

b. *Appropriate Facilities.*—The term “appropriate facilities” means that the institution is generally equipped to provide the needed hospital or skilled nursing care for the type of illness or injury involved. *It is the institution, its equipment, its personnel and its capability to provide the services necessary to support the required medical care that determine whether it has appropriate facilities.*

EXAMPLE: Mr. A becomes ill at home and requires ambulance service to the hospital. The hospitals servicing the community in which he lives are capable of providing general hospital care. However, Mr. A requires immediate kidney dialysis but the needed equipment is not available in any of these hospitals. The service area of the nearest hospital having dialysis equipment does not encompass the patient's home. Nevertheless, in this case, ambulance service beyond the locality to the hospital with the equipment would be covered since it is the nearest one with appropriate facilities.

The fact that a more distant institution is better equipped, either qualitatively or quantitatively, to care for the patient does not warrant a finding that a closer institution does not have “appropriate facilities.” However, a legal impediment barring a patient's admission would permit a finding that the institution did not have “appropriate facilities.” For example, the nearest tuberculosis hospital may be in another State and that State's law precludes admission of nonresidents.

An institution is not considered an appropriate facility if there is no bed available. The carrier, however, will presume that there are beds available at the local institutions unless the claimant furnishes evidence that none of these institutions had a bed available at the time the ambulance service was provided.

The individual physician who practices in a hospital is not a consideration in determining whether the hospital has appropriate facilities. Thus, ambulance service to a more distant hospital solely to avail a patient of the service of a specific physician or a physician in a specific specialty does not make the hospital in which the physician has staff privileges the nearest hospital with appropriate facilities.

c. *Ambulance Service to a Physician's Office is Not Covered.*—There may be situations where, in the course of transporting a patient to a hospital, the ambulance stops at a physician's office because of the patient's dire need for professional attention and immediately thereafter the ambulance continues the trip to the hospital. In such cases, the patient will be deemed not to have been transported to the physician's office and payment may be made for the entire trip.

Oxygen administered in connection with ambulance service is covered.,

B. *Transportation by ambulance to a hospital or extended care facility to obtain home health services* not available to the individual in his home is covered as a Part B service only if the three conditions in A above are met. Such transportation is not covered as a home health service.

216. PROSTHETIC DEVICES

Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ, and replacements or repairs of such devices, are covered when furnished incident to physicians' services or on a physician's order. For example, a cardiac pacemaker is covered as a prosthetic device. Dialysis equipment used in the treatment of renal failure is covered as a prosthetic device which replaces the function of a kidney. Supplies which are necessary for the effective use of such devices and equipment are also covered.

Dentures are excluded from coverage. However, where a denture or a portion thereof is an integral part (built-in) of a covered prosthesis (e.g., an obturator to fill an opening in the palate) it is covered as part of that prosthesis.

The term “internal body organ” includes the lens of an eye or all or part of an ear or nose. Prostheses replacing the lens of an eye include postsurgical lenses customarily used during convalescence from eye surgery in which the lens of the eye was removed. In addition, permanent lenses are also covered when required by an individual lacking the organic lens of the eye because of surgical removal or congenital absence. Prosthetic lenses obtained on or after the beneficiary's date of entitlement to supplementary medical insurance benefits can be covered even though the surgical removal of the crystalline lens occurred before entitlement.

In some cases, reimbursement may be made for more than one pair of prosthetic lenses. Subsequent prosthetic lenses medically required because of a change in prescription and combinations of prosthetic lenses determined to be medically necessary by a physician to restore essentially the vision provided by the crystalline lens of the eye are covered. Thus payment can be made for (1) both a contact lens and prosthetic lenses in frames, or (2) bifocal spectacles, or (3) prosthetic lenses in separate frames (far vision and near vision). Payment cannot be made for cataract sunglasses obtained in addition to the regular (untinted) prosthetic lenses, since the sunglasses duplicate the restoration of vision function performed by the regular prosthetic lenses.

218. LEG, ARM, BACK, AND NECK BRACES, TRUSSES, AND ARTIFICIAL LEGS, ARMS, AND EYES

These appliances are covered when furnished incident to physicians' services or on a physician's order. A brace includes rigid and semi-rigid devices which are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. Elastic stockings, garter belts, and similar devices do not come within the scope of the definition of a brace. Back braces include, but are not limited to, special corsets, sacroiliac, sacrolumbar, dorsolumbar corsets and belts. A terminal device (e.g., hand or hook) is covered whether or not an artificial arm is required by the patient.

Stump stockings and harnesses (including replacements) are also covered when these appliances are essential to the effective use of the artificial limb.

Purchase of the initial artificial limb or other appliance or replacement of such a device which has worn out or become unrepairable, or the replacement of usable appliances or artificial limbs required because of a change in the patients' physical condition are covered when supplied on a physician's order. Repairs to and adjustments of such appliances, where necessary, are also covered even when the appliance had been in use before the user enrolled in the supplementary medical insurance program.

220. DENTAL SERVICES

As indicated under the general exclusions from coverage (§ 237) items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not covered. Structures directly supporting the teeth means the periodontium, which includes the gingivae, dento-gingival junction, periodontal membrane, cementum of the teeth, and alveolar process.

However, payment may be made for (a) surgery related to the jaw or any structure contiguous to the jaw, or (b) the reduction of any fracture of the jaw or any facial bone, including dental splints or other appliances used for this purpose. (See also § 202.4.)

If an otherwise noncovered procedure or service is performed by a dentist as an incident to and as an integral part of a covered procedure or service *performed by him*, the total service performed by the dentist on such an occasion is covered.

Examples:

(1) The reconstruction of a ridge performed primarily to prepare the mouth for dentures is a noncovered procedure. However, where the reconstruction of a ridge is performed as a result of and at the same time as the surgical removal of a tumor (for other

than dental purposes), the totality of surgical procedures would be a covered service.

(2) Payment would be made for the wiring of teeth when this is done in connection with the reduction of a jaw fracture.

The extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease is also covered. This is an exception to the requirement that to be covered, a noncovered procedure or service performed by a dentist must be incident to and an integral part of a covered procedure or service performed by him. Ordinarily, the dentist extracts the patient's teeth, but another physician, e.g., a radiologist, administers the radiation treatments.

When an excluded service is the primary procedure involved, it is not covered regardless of its complexity or difficulty. For example, the extraction of an impacted tooth is not covered. Similarly, an alveoloplasty (the surgical improvement of the shape and condition of the alveolar process) and a frenectomy are excluded from coverage when either of these procedures is performed in connection with an excluded service, e.g., the preparation of the mouth for dentures.

Whether or not such services as the administration of anesthesia, diagnostic x-rays, and other related procedures are covered depends upon whether the primary procedure being performed by the dentist is itself covered. Thus, an x-ray taken in connection with the reduction of a fracture of the jaw or facial bone would be covered. However, a single x-ray or x-ray survey taken in connection with the care or treatment of teeth or the periodontium would not be covered.

Payment can be made for a covered dental procedure no matter where the service is performed.

Payment can also be made for services and supplies furnished incident to covered dental services. For example, the services of a dental technician or nurse who is under the direct supervision of the dentist or physician are covered if the services are included in the dentist's or physician's bill.

GENERAL EXCLUSIONS FROM COVERAGE

225. GENERAL EXCLUSIONS

No payment can be made under *either* the hospital insurance or supplementary medical insurance programs for certain items and services:

- A. Not reasonable and necessary (§ 226);
- B. No legal obligation to pay for or provide (§ 227);
- C. Furnished or paid for by government instrumentalities (§ 228);
- D. Not provided within United States (§ 229);
- E. Resulting from war (§ 230);
- F. Routine services and appliances (§ 231);
- G. Foot care services (§ 232);

- H. Supportive devices for feet (§ 233);
- I. Custodial care (§ 234);
- J. Cosmetic surgery (§ 235);
- K. Charges by immediate relatives of beneficiary's household (§ 236);
- L. Dental services (§ 237);
- M. Paid or expected to be paid under workmen's compensation (§ 238).

226. SERVICES NOT REASONABLE AND NECESSARY

Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member are not covered; e.g., payment cannot be made for the rental of a special hospital bed to be used by the patient in his home unless it is a reasonable and necessary part of the patient's treatment.

227. NO LOCAL OBLIGATION TO PAY FOR OR PROVIDE

Program payment may not be made for items or services which neither the beneficiary nor any other person or organization has a legal obligation to pay for or provide. This exclusion applies where items and services are furnished gratuitously without regard to the individual's ability to pay, and without expectation of payment from any source, such as free x-rays or immunizations provided by health organizations. However, Medicare coverage is not excluded where a third party, rather than the patient, is obligated to pay for or provide the items and services. Furthermore, reimbursement is not precluded merely because a provider, physician, or supplier waives the charge in the case of a particular patient or a group or class of patients, as the waiver of charges for some patients does not impair the right to charge others, including Medicare patients. The determinative factor in applying this exclusion is the reason the particular individual is not charged.

The following sections illustrate the applicability of this exclusion to various situations involving services furnished by nongovernmental providers. (For a discussion of services paid for by a government instrumentality, see § 228.)

A. Medicare Patient Has Other Insurance.—Payment is not precluded under Medicare even though the patient is covered by another health insurance plan or program which is obligated to provide or pay for the same services. This plan may be the type which pays money toward the cost of the services, such as a health insurance policy, or it may be the type which organizes and maintains its own facilities and professional staff. Examples of this latter type are employer and union sponsored plans which furnish services to special

groups of employees or to union members, and group practice prepayment plans.

It was clearly intended by the Congress that Medicare should constitute the basic health insurance for aged individuals which they may supplement with additional protection through private or group insurance.

However, services which are covered under a workmen's compensation policy are specifically excluded from coverage under Medicare. (See § 238.)

B. Third Person Liability.—Services are covered by Medicare even though the patient's need for treatment for an injury resulted from the negligence of another party who is or may be legally liable for the patient's medical expenses. The existence of the other person's liability does not affect the Medicare patient's obligation to pay for the services he receives.

C. Ambulance Services.—There are numerous methods of financing ambulance companies. For example, some volunteer organizations do not charge the patient or any other person but ask the recipient of such services for a donation to help offset the cost of the service. Although the recipients may be under considerable moral and social pressure to donate, *they are not required to do so*, and there is no enforceable legal obligation on the part of the individual or anyone else to pay for the services. Thus, Medicare benefits would not be payable. However, services of volunteer ambulance corps are not categorically excluded. Many such companies regularly charge for their services and these services are covered by Medicare.

Some ambulance companies provide services without charge to residents of specific geographical areas who do not have private insurance to cover such services; where the patient does have insurance, the ambulance company expects the insurer to pay for the services. Since the ambulance company does not provide free services for insured individuals, and all patients would be charged if insured, a legal obligation to pay exists and the services are covered. If, however, the residents receive free services *without exception*, but the ambulance company charges nonresidents to the extent they are able to pay (e.g., through private insurance), the free services provided the residents would be excluded from coverage, while the services furnished non-residents would be covered.

228. ITEMS AND SERVICES FURNISHED OR PAID FOR BY GOVERNMENT INSTRUMENTALITIES

The Medicare law places limitations on the circumstances under which payment may be made for items and services furnished or paid for by State, local, or Federal Government instrumentalities. The law contains separate limitations applicable to Federal providers of services, items and services which the pro-

vider or supplier is obligated under a Federal Government contract or law to furnish at public expense (§ 228.1), and items and services paid for directly or indirectly by a government entity (State, Federal, or local) (§ 228.2). The following sections discuss these limitations in greater detail and how they are to be applied under various circumstances.

228.1 Items and Services Which the Provider or Supplier is Obligated to Furnish Under a Federal Government Contract or Law.—Payment may not be made for items or services which a provider or other person is obligated by law of, or contract with, the United States to render at public expense.

228.2 Items and Services Which Are Paid For Directly or Indirectly by a Government Entity.

A. General.—Benefits are not payable under Medicare for items and services paid for by an agency of a State or local government or of the Federal Government, except as specified in B and C below. This exclusion applies to services furnished by government operated facilities as well as services furnished by non-governmental facilities which are paid for by a governmental agency.

b. Statutory Exceptions.—The exclusion of items and services paid for by a governmental entity does not apply in the following situations; therefore, payment may be made under Medicare where:

1. The items or services are furnished under a health benefits or insurance plan established for employees of the governmental entity; and

2. The items or services are furnished under one of the titles of the Social Security Act (such as medical assistance under title XVI or XIX).

C. Exceptions Approved by the Secretary.—The Secretary of Health, Education, and Welfare is authorized by law to specify additional exceptions to this exclusion. The Secretary has approved Medicare payment for services provided or paid for by a governmental entity in the following additional situations:

1. The items or services are furnished by a participating State or local government-operated hospital, including a psychiatric or tuberculosis hospital, which serves the general community. A psychiatric hospital to which patients convicted of crimes are committed involuntarily is considered to be serving the general community if State law provides for voluntary commitment to the institution. However, payment may not be made for services furnished in State or local hospitals which serve only a special category of the population, but do not serve the general community, e.g., prison hospitals; and

2. The items or services are paid for by a State or local governmental entity and furnished an individual

as a means of controlling infectious diseases or because the individual is medically indigent. These services need not be furnished in or by a hospital.

229. SERVICES NOT PROVIDED WITHIN THE UNITED STATES

Items and services which are not provided within the United States are not covered (except for emergency inpatient hospital services furnished outside the United States under certain limited conditions and payment on behalf of railroad beneficiaries for covered hospital insurance services furnished in Canadian hospitals). The United States includes the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

The United States also includes the territorial waters adjoining the above entities. Generally speaking, the 3-mile limit off the shores of most of the United States constitutes American territory. In the case of Texas and Florida, the limit extends into the Gulf of Mexico within 9 miles (3 leagues) off the shores of these States. A ship or aircraft, even of American registry, is not considered to constitute American territory when it is not within or above the land area or territorial waters of the United States.

230. SERVICES RESULTING FROM WAR

Items and services which are required as a result of war, or of an act of war, occurring after the effective date of the patient's current coverage are not covered.

231. ROUTINE SERVICES AND APPLIANCES

Routine physical checkups; eyeglasses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; hearing aids and examinations for hearing aids; and immunizations are not covered.

Routine physical checkups include (a) examinations performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury, and (b) examinations required by third parties such as insurance companies, business establishments, or Government agencies.

Vaccinations or inoculations are excluded as "immunizations" unless they are directly related to the treatment of an injury or direct exposure such as anti-rabies treatment, tetanus antitoxin, or booster vaccine, botulin antitoxin, antivenin or immune globulin.

The exclusions apply to eyeglasses or contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors. The exclusions do not apply to physicians' services (and services incident to a physician's service) performed in conjunction with an eye disease, as for example glaucoma or cataracts, or to postsurgical prosthetic lenses which are customarily used during convalescence from eye surgery in which the lens of the eye was removed, or to permanent prosthetic

lenses required by an individual lacking the organic lens of the eye, whether by surgical removal or congenital absence. Such prosthetic lens is a replacement for an internal body organ—the lens of the eye. (See § 216.)

Effective January 2, 1968, procedures performed during the course of any eye examination to determine the refractive state of the eyes are also excluded. Thus, expenses for *all* eye refraction procedures, whether performed by an ophthalmologist (or any other physician) or by an optometrist and without regard to the reason for the performance of the refraction, are excluded from coverage under the program. Refractive procedures are excluded from coverage even if the procedures are performed by a physician in connection with the diagnosis or treatment of an eye disease or injury, or for the purpose of prescribing or providing prosthetic lenses. Although payment can be made for the prosthetic lenses (e.g., following cataract surgery) and any incidental charges that may be assessed for fitting them, no payment can be made in such cases for the procedures performed to determine the refractive state of the eyes.

The following guidelines are used for determining reasonable charges for refractive procedures: In a comprehensive ophthalmological examination (e.g., an initial eye examination) which may include refractive procedures, the value of the procedures performed to determine the refractive state of the eyes may generally be expected to be about 20 percent of the reasonable charge for the total comprehensive examination. In a follow-up examination (where refractive procedures are performed) the value of the refractive procedures, as a per cent of the total charge, is generally higher; although professional estimates vary, the most common view is that refractive procedures represent approximately 33⅓ per cent of the total reasonable charge for a follow-up examination.

232. FOOT CARE EXCLUSION

Effective January 2, 1968, the following types of foot care services are excluded from coverage. See § 202.3 for coverage of podiatrists' services.

A. Treatment of Flat Foot Conditions and Prescription of Supportive Devices Therefor.—For the purpose of this exclusion, treatment of “flat foot conditions” means treatment of the local condition of flattened arches regardless of the underlying pathology causing it, except where such treatment is purely incidental to and an integral part of covered foot treatment (for example, treatment of a fracture). The term “treatment” encompasses all phases of services in connection with flat feet, including evaluations as well as any measures or devices designed either to correct the condition or to palliate pain and other symptoms associated with the condition.

B. Treatment of Subluxations of the Foot.—For the purpose of this exclusion, the term “subluxation” refers to structural misalignments of the joints of the feet (except fractures and complete dislocations) which do not require treatment by surgical methods. Such structural misalignments of the feet include a variety of conditions in which the normal relationship of the bones, tendons, ligaments, and supporting muscles is disturbed and which, regardless of underlying pathology, require treatment only by mechanical methods such as whirlpool or paraffin baths, casting, strapping, splinting, padding, corrective footwear and devices, and use of other appliances, electrical therapy, such as short wave or low voltage currents, and physical therapy, exercise, manipulation, and massage. Excluded “treatment” of the above conditions includes evaluations as well as the nonsurgical measures, supplies, or appliances used to correct the condition or alleviate symptoms. The exclusion does not apply where such treatment is purely incidental to and an integral part of covered foot treatment (such as treatment of a fracture) or where performed as a part of postoperative care during the period of convalescence from covered foot surgery.

This exclusion does not apply to the ankle joint (talo-crural joint).

C. Routine Foot Care.—Routine foot care includes the cutting or removal of corns, warts, or calluses, the trimming of nails, and routine hygienic care. “Routine hygienic care” includes hygienic and preventive maintenance care of the feet, of the type which is ordinarily within the realm of self-care, such as observation and cleansing of the feet, use of skin creams to maintain skin tone of both ambulatory and bedfast patients, nail care not involving surgery, prevention and reduction of corns, calluses and warts, and any services performed in the absence of localized illness, injury, or symptoms involving the foot.

The above types of “routine” care are excluded regardless of the reason for such care. Thus, the fact that a particular individual is unable to perform certain care for himself (for example, because of a physical disability or a predisposing systemic disease such as diabetes or peripheral vascular disease which makes preventive hygienic foot care particularly important) does not change the character of the services and make them “nonroutine.” Hygienic and other care which is simply incidental to and an integral part of active covered treatment of foot lesions, such as infections and diabetic ulcers, is not considered as “routine” care and hence is not excluded.

232.1 Application of Foot Care Exclusions to Physicians Services.—Charges are excluded for *any* services in connection with noncovered foot care unless such services are performed inciden-

tally to, at the same time as, and as a necessary integral part of a primary covered procedure. The only exception to this rule applies where diagnostic services or procedures are performed in connection with a specific symptom or complaint; in such situations, payment may be made for the initial diagnostic services regardless of the resulting diagnosis.

If a physician's total charge relates to noncovered services (for example, routine foot care or nonsurgical treatment solely in connection with disturbances such as foot strain, separation of metatarsal bones, and foot weakness, imbalance or instability), the entire charge is excluded.

If the primary procedure is a covered service and all services performed were directly related to the primary procedure, the physician's total performance on such occasion, including any incidental otherwise noncovered services, are covered. (For example, trimming of toenails is required for application of a cast for the reduction of a foot fracture.) Where an excluded service is the primary procedure involved (e.g., surgical removal of a wart), it is not covered regardless of its complexity or difficulty.

The coverage or exclusion of any given foot treatment depends on the nature of the service and not on whether it was performed by a podiatrist, osteopath or doctor of medicine. Whether administration of an anesthetic is covered depends on whether the primary procedure being performed by the physician is itself covered.

233. SUPPORTIVE DEVICES FOR FEET

Orthopedic shoes or other supportive devices for the feet are not covered. The exclusion of orthopedic shoes does not apply to such a shoe if it is an integral part of a leg brace. Where an orthopedic shoe is built into a leg brace, reimbursement is made not specifically for the shoe but is based on the reasonable charge for the entire leg brace of which the shoe is an integral part.

234. CUSTODIAL CARE

The custodial care exclusion precludes payment for that type of care, wherever furnished, which is designed essentially to assist the individual in meeting his activities of daily living—i.e., services which constitute personal care such as help in walking and getting in or out of bed, assistance in bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision over medication which can usually be self-administered—and which does not entail or require the continuing attention of trained medical or paramedical personnel.

Periodic visits by a physician to his patient are covered under Part B if reasonable and necessary to the treatment of the patient's illness or injury. Such physi-

cian services are reimbursable even though a finding has been made that the care furnished the patient in the hospital or extended care facility is custodial care and, therefore, not covered.

235. COSMETIC SURGERY

Cosmetic surgery or expenses incurred in connection with such surgery is not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, or to surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose.

236. CHARGES IMPOSED BY IMMEDIATE RELATIVES OF THE PATIENT OR MEMBERS OF HIS HOUSEHOLD

A. General.—Payment may not be made under medical insurance for expenses which constitute charges by immediate relatives of the beneficiary or by members of his household. The intent of this exclusion is to bar Medicare payment for personal services of physicians or suppliers which would ordinarily be furnished gratuitously because of the relationship of the beneficiary to the person imposing the charge. Payment may be made, however, for reasonable charges imposed on such individuals by a physician or supplier to recover out-of-pocket expenses he has incurred in furnishing covered items or supplies, e.g., expenses for covered drugs and biologicals, prosthetic devices, etc. In such cases, the charge may not exceed the physician's or supplier's actual out-of-pocket costs.

B. Services of Providers and Provider-Based Physicians.—This exclusion applies only to services reimbursed on a charge basis and does not apply to provider services and to the services of GPPP's which are reimbursed for their costs rather than charges. Thus, reimbursement may be made for covered services furnished by a provider to an owner of the institution or to an immediate relative of an owner, or a member of an owner's household.

Reimbursement may not be made, however, for the professional component of services of provider-based physicians furnished to an immediate relative of the physician or to a member of the physician's household. Since the personal services of provider-based physicians are billed on a charge basis, they would be subject to this exclusion whether the bill is submitted by the physician or, with his authorization, by the provider.

C. Immediate Relative.—The following degrees of relationship are included within the definition of “immediate relative”: (1) Husband and wife; (2) natural parent, child, and sibling; (3) adopted child and adoptive parent; (4) stepparent, stepchild, stepbrother, and stepsister; (5) father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; (6) grandparent and grandchild.

D. Members of the Patient’s Household.—These are persons sharing a common abode with the patient as a part of a single family unit, including those related by blood, marriage or adoption, domestic employees and others who live together as part of a single family unit. A mere roomer or boarder is not included.

E. Charges by Business Organizations such as Suppliers and Clinics.—Charges imposed by a medical group, clinic or supplier which is not a corporation are, in effect, imposed by the owner or owners of the business. Thus, this exclusion applies where such a firm is owned by a sole proprietor who bears one of the excluded relationships to the patient or, in the case of a partnership, where all of the partners are within the excluded relationships. Since a corporation is a separate legal entity, the charges it imposes would not be subject to this exclusion regardless of the relationship of the patient to the corporation’s owner or owners.

237. DENTAL SERVICES EXCLUSION

Items and services in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth are not covered. “Structures directly supporting the teeth” mean the periodontium, which includes the gingivae, dento-gingival junction, periodontal membrane, cementum, and alveolar process.

Payment may be made, however, for (a) surgery related to the jaw or any structure contiguous to the jaw, or (b) the reduction of any fracture of the jaw or any facial bone, including dental splints or other appliances used for this purpose.

See also §§ 202.4 and 220 for additional information on dental services.

238. ITEMS AND SERVICES UNDER A WORKMEN’S COMPENSATION LAW

Items and services to the extent that payment has been made, or can reasonably be expected to be made for items or services under a workmen’s compensation law or plan of the United States or a State may not be paid for by the program. Payments made for items and services under the health insurance program are subject to repayment to the appropriate trust fund if notice or information is received that payment has been made for the items and services under a workmen’s compensation plan.

245. DEDUCTIBLE

In each calendar year a deductible of \$50 must be satisfied before Part B payment can be made. Noncovered medical expenses do not count toward meeting the deductible. The blood deductible (§ 249) must be met separately and cannot be applied toward the \$50 deductible. The \$50 deductible can be met only by covered Part B expenses incurred by the beneficiary. The reasonable charges for covered Part B expenses are counted toward satisfying the \$50 deductible on an incurred basis, whether or not they have been paid. Expenses for radiologist and pathologist services furnished to hospital inpatients, for which benefits of 100 percent are payable, may not be credited toward the deductible.

A member of a GPPP need not be concerned about the deductible for services which he receives from the plan.

245.1 Direct-Dealing GPPP’s.—A special rule is applied to calculate the deductible for members of GPPP’s which deal directly with the Social Security Administration. Once a month SSA credits each plan member with a fixed portion of the premium toward the deductible for that year. If in any year a member uses only covered services furnished by the plan, the deductible will be fully covered. If during the year, an individual receives covered services which are not provided by the plan, credit toward the \$50 deductible at that time will depend on the accumulated credits for the months of the year in which the individual has paid premiums to the plan and any other expenses incurred by the individual which count toward meeting the deductible. (See § 318 for a discussion of the pro-rata deductible.)

245.2 Carryover Credits Toward the \$50 Deductible.—Part B covered expenses that are incurred in the last three months (October, November, December) of a calendar year which are counted toward meeting the \$50 deductible for that year will be counted toward satisfying the \$50 deductible for the following calendar year. The monthly pro rata amount credited to a member of a GPPP will not be counted toward satisfying the \$50 deductible for the following year. The carryover provision is taken into account in computing the GPPP’s average weighted deductible (§ 316.1).

245.3 Order in Which Expenses are Credited.—Except to the extent that the prior year’s expenses are counted, the deductible is satisfied by the initial medical insurance expenses incurred in the current year. The date of service determines when expenses were incurred, but expenses will be allocated to the deductible in the order in which the bills for those

expenses are received by the carrier. An adjustment must be made, however, when expenses incurred in the 4th quarter of one year are used to satisfy the deductible for the following year and it is subsequently determined that the patient had incurred covered expenses prior to the 4th quarter of the earlier year.

245.4 Applicability of \$50 Deductible in Year of Enrollment or Termination.—Even though an individual may not be eligible for Part B coverage for the full calendar year, e.g., he attains age 65 in a month after the first month of the year or his entitlement ends before the last month, he must still meet the full \$50 deductible for that year.

247. COINSURANCE

Medicare payment is subject to a 20 percent coinsurance provision after the \$50 deductible has been satisfied. Medicare pays 80 percent of the reasonable charges incurred during the balance of the calendar year. GPPP's that elect "reasonable cost" reimbursement will be paid 80 percent of the "reasonable costs." (Radiologist and pathologist services to inpatients of qualified hospitals are based on 100 percent reimbursement of reasonable charges (§ 202.7).)

249. MEDICAL INSURANCE BLOOD DEDUCTIBLE

A. Summary of Provision.—Blood furnished under Part B on or after January 1, 1968 is subject to a deductible. This deductible applies to the first three pints of blood or equivalent quantities of packed red cells received by a beneficiary in a calendar year. (See § 204.1 for coverage of blood under Part B.)

Reimbursement for blood furnished under Part B after the patient has received three pints in a calendar year will be subject to the Part B \$50 deductible and coinsurance (§§ 245 and 247) provisions. Expenses incurred in meeting the Part B blood deductible (and the value of replacements made for such blood) do not count as incurred expenses under Part B for purposes of meeting the \$50 deductible or for purposes of reimbursement. Even though the Part B blood deductible for any calendar year is satisfied in whole or in part during the last three months of the calendar year, there is no carryover credit toward the blood deductible in the following calendar year.

Blood furnished under Part A is subject to a deductible that applies to the first three pints furnished in each benefit period. The Part A and Part B deductibles are applied separately regardless of whether one or the other has been met.

B. Scope of Blood Deductible.—Only whole blood or equivalent quantities of packed red cells is subject to the deductible. Whole blood is human blood from which none of the liquid or cellular compo-

nents has been removed. Where packed red cells are furnished, a unit of packed red cells is considered equivalent to a pint of whole blood.

The blood deductible does not apply to other blood derivatives such as platelets, plasma, globulin, fibrinogen and serum albumin; however, these components and derivatives of whole blood are covered biologicals for which reimbursement under the medical insurance program may be made (subject to the \$50 deductible and coinsurance provisions).

C. Application of the Blood Deductible.—

1. Charges for Blood or Red Cells Furnished by a Physician or Clinic.—Physician or clinic charges for deductible pints of blood or units of packed cells cannot be paid for under the program if the blood is not replaced. Blood is considered replaced when one pint or unit is returned for each pint or unit furnished. Where the physician obtains the blood from a blood bank, see paragraph 3 below.

2. Processing Charges by a Physician or Clinic Administering Blood.—Charges by the physician or clinic for processing, storing, or administering the deductible blood are not subject to the blood deductible and may be paid for subject to the regular deductible and coinsurance whether or not the blood is replaced.

3. Replacement Provision Where Physician or Clinic Obtains Blood From Blood Banks.—

a. General.—Where a physician or clinic has furnished a beneficiary deductible pints or units of blood obtained from an independent blood bank and the blood was replaced at least pint-for-pint on behalf of the individual, the physician's or clinic's reasonable charge may include charges made by the blood bank after credit for the replacement; however, such charge may not exceed 2/3 of the amount the blood bank would have charged for those pints had they not been replaced. If the blood was not replaced, the blood bank's charge cannot be included in the physician's reasonable charge.

b. Blood Furnished by Bank Without Charge to Physician or Clinic.—When blood received by the beneficiary is furnished without charge to the physician or clinic by a voluntary blood bank, such as the American Red Cross, the physician's or clinic's "reasonable charges" for the transfusion cannot include any charge for the blood itself. However, a reasonable physician or clinic charge may be included for services furnished (typing, processing, transportation of the blood, etc.). The blood deductible does not apply to these charges.

c. Bank Makes Service Charge for All Blood.—If the blood bank makes a service charge to the physician or clinic which applies whether or not the blood is replaced, this service charge, to the extent

reasonable, constitutes an "incurred expense" without regard to the blood deductible status.

d. *Bank Makes Service Charge Only for Unreplaced Blood.*—Where the service charge is made only for unreplaced blood, this charge will be considered a charge for blood, and, therefore, subject to the blood deductible requirement.

Psychiatric Services Limitation

255. PSYCHIATRIC SERVICES LIMITATION EXPENSES INCURRED FOR PHYSICIAN SERVICES

Regardless of the *actual* expenses for physicians' services and any items or supplies furnished by a physician in connection with his services incurred in connection with the diagnosis and treatment for mental, psychoneurotic or personality disorders of persons who are not inpatients of hospitals, the amount of such expenses that can be counted in a calendar year is limited to the lesser of \$312.50 or 62.5 per cent of the actual expenses. The computation of psychiatric expenses for deductible purposes is also subject to the 62.5 per cent rule. Since \$312.50 represents 62.5 per cent of \$500, any amount of noninpatient psychiatric service expense in excess of \$500 would not be considered in computing incurred expenses subject to reimbursement. Since the program's share of covered incurred expenses (after the \$50 deductible) is 80 per cent of the charges, the maximum possible payment for services would be 80 per cent of \$312.50 or \$250. This maximum could be reached only if the individual has had \$50 of incurred expenses other than noninpatient psychiatric service expenses. Where the beneficiary does not have any incurred expenses other than the noninpatient psychiatric service expenses, the maximum possible payment by the program would be \$210. (See §§ 324 and 416 for application of the limitation to GPPP's.)

256. PSYCHIATRIC SERVICES LIMITATION COMPUTATION

To compute the benefit:

1. Consider all psychiatric expenses incurred up to a maximum of \$500, whether or not applied to the deductible.
2. Multiply by .625.
3. Subtract any unsatisfied deductible.
4. Multiply by .8.

Example A: In 1967, patient A had psychiatric treatment while not an inpatient and incurred total expenses of \$600. The benefit payable is computed as follows: \$500 (maximum incurred expenses) \times .625 = \$312.50. Since no part of the deductible has been satisfied for the year, subtract \$50, leaving \$262.50. The benefit payable is \$210 (80 per cent of \$262.50).

Example B: Assume total psychiatric expenses while not an inpatient to be \$800. \$25 of nonpsychiatric expenses had previously been incurred and applied toward the deductible. The benefit payable is computed as follows: \$500 (maximum incurred expenses) \times .625 = \$312.50. Since \$25 of the deductible has already been satisfied subtract \$25, leaving \$287.50. The benefit payable is \$230 (80 per cent of \$287.50).

Example C: Assume total psychiatric expenses while not an inpatient to be \$35. \$28 of nonpsychiatric expenses had previously been incurred and applied toward the deductible. The computation is as follows: \$35 \times .625 = \$21.88. Since \$22 of the deductible remains unsatisfied, and only \$21.88 may be applied to the \$22, the deductible has not been met and no payment would be made.

Example D: A beneficiary is receiving psychiatric treatment during 1967. He visits the psychiatrist's office once a week and the charge for these visits is \$25 per visit. His total bill for services through October 20 is \$400. On that date he is hospitalized for an acute mental disturbance and continues to receive treatment through the end of the year. A Request for Payment form for \$750 in Part B charges is submitted. There are no other Part B medical expenses during the year. The total bill for services while the beneficiary was not an inpatient is \$400. Sixty-two and one-half per cent of this amount is \$250. After subtraction of the deductible, 80 percent of the \$200 balance can be paid. Since the remaining \$350 in Part B charges were for services while the beneficiary was an inpatient, 80 percent of this amount may be paid as if they were regular medical (nonpsychiatric) expenses.

257. APPLICATION OF THE LIMITATION

The term "mental, psychoneurotic, and personality disorders" is defined as the specific psychiatric conditions described in the American Psychiatric Association's *Diagnostic and Statistical Manual—Mental Disorders*. The limitation applies only to expenses incurred for physicians' services rendered in connection with one of these psychiatric conditions (with no distinction being made between the services of psychiatrists and nonpsychiatrist physicians), and any items or supplies furnished by the physician in his own office. Services furnished by other health personnel including home health services and outpatient hospital services would not be subject to the special psychiatric limitation even though the services are in connection with a condition included in the definition of "mental, psychoneurotic, and personality disorders."

The Act specifies that the limitation is applicable to expenses incurred in connection with the treatment of an individual who is *not an inpatient of a hospital*. Thus, the limitation is applicable to services furnished

by physicians in outpatient departments in a physician's office, the patient's home, an extended care facility, and so forth. The term "hospital," in this context means a hospital which is primarily engaged in providing by or under the supervision of physician(s), to inpatients (1) diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled, or sick persons, or rehabilitation services for injured, disabled, or sick persons; or (2) psychiatric services for the diagnosis and treatment of mentally ill persons; or (3) medical services for the diagnosis and treatment of tuberculosis.

258. DETERMINING WHEN THE LIMITATION APPLIES

Where the physicians' services rendered are both for a psychiatric condition as defined in § 257 and one or more nonpsychiatric conditions, it will be necessary to separate the charges for the psychiatric aspects of treatment from the charges for the nonpsychiatric aspects of treatment. However, in any case in which the psychiatric and nonpsychiatric components are not readily distinguishable, all of the charges will be allocated to the primary diagnosis.

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REIMBURSEMENT TO DIRECT DEALING PLANS

300. INTRODUCTION

This chapter sets forth guidelines and procedures for use by GPPP's that deal directly with the Social Security Administration.

Allowances will be made for variances in administration processes where such variance does not interfere with the efficient management of the reimbursement function and does not infringe on any provision of law or regulation. The need for flexibility is due to the difference in size, scope, enrollment, and administration of various GPPP's.

302. METHODS OF REIMBURSEMENT

The law permits a GPPP to elect reimbursement on a reasonable cost basis. Before such election may be effected, it must be determined by SSA to be administratively feasible to reimburse the plan on this basis. Plans receiving reasonable cost reimbursement deal directly with the Social Security Administration.

Upon administrative approval, the election becomes applicable to all covered Part B services furnished or made available by the plan to Part B beneficiaries who are plan members. Reimbursement cannot be made on a "reasonable cost" basis for some covered member services and on a "reasonable charge" basis for others. Once elected and approved, the plan will continue to receive reasonable cost reimbursement until it writes the Administration that it wishes to change to reasonable charge reimbursement. The plan would be permitted to make the change effective with the beginning of its next accounting year provided it notifies the Administration at least 90 days prior to the effective date of the change.

Plans receiving reimbursement on the basis of reasonable charges related to cost may also deal directly with SSA on a non-bill basis. (See § 303.)

303. REASONABLE CHARGE REIMBURSEMENT ON A NON-BILL BASIS

This method differs from the other procedures for reimbursement on a reasonable charge basis in that:

1. The plan, with the consent of the Secretary, may deal directly with the Social Security Administration, and
2. The plan will not need to file individual bills for services rendered. (However, statistical reporting of medical services on Forms SSA-1590 and/or 1591 will be required. See § 390B.)

Reimbursement under this method will result in Medicare members sharing in the plan's total costs to the same extent as other plan members. Non-Medicare members of the plan will no longer be required to

subsidize the Medicare member for those amounts in excess of the budgeted costs of providing medical care which the plan requires to operate effectively.

A. The Equalization Payment

Plans vary in the ways they compute their total financial requirements and how the amount in excess of budgeted costs should be determined. However, regardless of how it is computed the amount will be recognized if it meets the following criteria:

1. It is a reasonable amount acceptable to the Administration.
2. It is charged equally to plan members not covered under Medicare. (A plan which does not include such factors in its premium structure will be allowed to include them in its formula for determining reimbursement under Medicare only if they are made applicable to all other plan members.)
3. The plan must exclude from this factor any portion which is to be used for costs not otherwise reimbursable under the Medicare program, e.g., sales promotion, advertising, etc. The plan must show how it arrived at the amount of the factor and the purposes for which the funds collected will be used.
4. The plan must attest that this factor was not included in the amount of premiums payable to the plan by enrollees covered under Medicare. The plan will be required to show the components which are included in the total premium amount to demonstrate that this factor was not included.

The factor will be applied in determining reimbursement under Medicare in the same way in which the plan applies it to the premiums of other plan members. Thus, if this factor is added as a flat amount to the premiums of each member of the plan it will be reimbursed by Medicare as a flat amount per Medicare enrollee. If on the other hand the plan adds a percentage to premiums, this percentage will be applied to the payments under Medicare. This factor will not be subject to retrospective adjustment where a fixed amount or percentage is determined by the plan at the beginning of its accounting year. Although funding of this factor is not required, it is strongly recommended that plans use this mechanism as a means of conserving these funds for the purposes for which they are intended. Any diversion of these funds for purposes other than those indicated above may affect allowance of the equalization factor for the following year.

B. Method of Reimbursement

Payments to GPPPs under this method of reimbursement should equal the present payments being made to GPPPs that are reimbursed on a reasonable cost basis, plus the inclusion of the equalization factor. Because payments to the plans will be made on other than an individual bill basis, payments will be subject

to retrospective adjustment (except for the equalization factor as described above.)

A weighted average deductible will be computed for GPPPs on a reasonable charges non-fee-for-service basis in the same manner as it is for GPPPs being reimbursed on a reasonable cost basis. (See § 316.) Similarly the plan member will be given credit on his deductible record in the Administration tapes for that portion of his premium which applies toward the deductible and coinsurance (§ 318).

The following sets forth the conditions under which payment will be made:

1. The basic methods of cost finding and allocation of costs currently being used for reimbursement on a reasonable cost basis will apply (see § 304ff).

2. The plan will receive interim payments on a per capita or other non-fee-for-service basis subject to retrospective adjustment at the end of its accounting year.

3. The plan must have adequate records and be able to identify its membership before it can be reimbursed.

304. COST DETERMINATION

A GPPP being reimbursed on a reasonable cost basis must have sufficient cost and enrollment data to allocate its total costs of covered medical services between its beneficiary and non-beneficiary enrollees. Reimbursement will be made to the plan for all covered medical services furnished its beneficiary-enrollees. This includes cost of the medical services furnished by the plan's physicians, plus other expenses of the plan as are related to such medical care and furnished by clerical, technical, and other professional personnel. Other covered medical costs may be incurred by the plan for "purchased services," e.g., radiology, anesthesiology, pathology, or psychiatry services in the hospital or clinic, super-specialist services including such procedures as open heart or brain surgery, and emergency services in and out of area. All of these services are an integral part of the plan's cost of providing the covered medical services. Because these costs cannot be precisely determined in advance, they are subject to retroactive adjustment on the basis of actual experience.

Some GPPP's contract with medical groups to provide medical services to plan members for a specified amount of money per person for a stated period of time. This fixed contractual rate per person per year paid by the plan to the medical groups, which becomes part of the plan's cost, includes all covered medical services of the medical groups' physicians, plus other expenses of the medical groups related to medical care, technical and other professional personnel.

Such fixed costs, therefore, would not be subject to retroactive adjustments. However, all other covered

medical costs for which the plan has no fixed contractual obligation are subject to retroactive adjustment on the basis of actual experience.

The Administration may approve certain cost factors, such as a plan's contractual payments to its medical groups, as "not being subject to retroactive adjustment." However, in such instances the plan must agree that such cost factors may be appropriately reduced if any payments were increased by a significant amount because the estimates or date upon which approval was based were incomplete, inaccurate, noncurrent or inadequate.

306. REASONABLE COST REIMBURSEMENT

306.1 *Allocating Applicable Costs.*—The law provides that costs with respect to individuals covered by Medicare are not to be borne by individuals without Medicare coverage and that costs with respect to individuals without Medicare coverage are not to be borne by the program.

Total allowable costs of a plan for providing, or making available, medical and other health services must be apportioned between Medicare beneficiaries and other enrollees so that reimbursement from the program reflects the costs for services furnished program beneficiaries.

306.2 *Administrative Costs.*—Administrative costs are recognized as being ordinary and necessary costs in the operation of a plan. Such costs may or may not be related to the quantity of medical services rendered during a year. To provide a suitable basis for allocation, administrative costs must be broken down into two categories—direct and indirect costs.

306.3 *Direct administrative costs* include those associated with medical care expenses in a clinic or other medical setting such as depreciation on furniture and fixtures, maintenance of clinic, supplies used in providing clinic services, taxes on clinic building, etc. These would be added into the direct costs associated with providing medical care and be allocated accordingly.

Costs related to participation in Medicare which are not related to furnishing care must be kept separately and will be reimbursed separately (see § 370).

306.4 *Indirect administrative costs*, on the other hand, are not directly associated with providing medical care. Such costs would include, but would not be limited to salaries of officers, executives, and general office personnel; travel; legal and auditing fees; office building supplies; telephone and telegraph expenses; postage; taxes; and subscriptions to publications and dues for appropriate organizations. These must be allocated on a per capita basis.

308. COSTS OF PROVIDING MEDICAL CARE

Payment to plans is to be made with due recognition of the resources used in rendering covered medical services. This involves recognition of the extent to which beneficiaries utilize the covered medical services available (utilization factor) as well as the cost differential related to the expenditures of physician time in providing services to Medicare beneficiaries as compared to the time spent in treating nonbeneficiaries (time factor).

A time factor based on plan records (or an acceptable sampling of such records) will be allowed in making reimbursement to a GPPP. In lieu of its own time factor, a GPPP may use a standard time adjustment factor of 20 percent. This 20 percent allowance is subject to modification by the Social Security Administration.

In general, the method chosen by a plan to determine its utilization factor will determine the manner in which the time factor must be developed. If the utilization ratio is determined by comparing the services used by individuals age 65 and over to those used by persons under age 65, the time factor would be devel-

oped by comparing the time taken to render services to persons age 65 and over to the time taken to render services to persons under age 65.

A. One method of allocating costs is to determine the ratio of service utilization between beneficiary and nonbeneficiary plan members. This ratio, adjusted for the time factor and applied to the plan's covered costs, would establish the proportion of the costs applicable to Medicare beneficiaries.

Example

A plan has 10,000 members of which 1,000 are Medicare beneficiaries. The plan's records show that the plan has rendered 26,000 covered services to all members in 1967, of which 6,000 were to Medicare beneficiaries. (See § 200 for definition of covered service.) The plan's cost for rendering all covered services for 1967, including direct but excluding indirect administrative costs, was \$234,000. Note: It is assumed that the number of noncovered services has been excluded as well as the costs associated with time.) Indirect administrative costs amounted to \$15,000. The costs applicable to Medicare beneficiaries would be determined by the following computation:

1. Total plan membership	10,000
2. Medicare membership	1,000
3. Percent of Medicare membership (line 2 divided by line 1)	10%
4. Total covered services rendered to all members	26,000
5. Total covered services rendered to Medicare beneficiaries	6,000
6. Total covered services rendered to non-Medicare members (line 5 subtracted from line 4)	20,000
7. Adjustment for time factor (line 5 multiplied by 1.2)	7,200
8. Total adjusted covered services for all members (line 6 plus line 7)	27,200
9. Ratio of covered services of Medicare beneficiaries adjusted for the time factor (line 7 divided by line 8)	26.5%
10. Direct costs applicable to Medicare beneficiaries (Total covered costs multiplied by line 9—\$234,000 x 26.5%)	\$62,010
11. Indirect administrative costs (\$15,000 multiplied by line 3)	1,500
12. Total cost applicable to Medicare beneficiaries (line 11 plus line 10)	\$63,510

B. A more refined method for allocating costs is to assign a service unit value, based on appropriate relative value scales, to each covered service rendered a plan member. The ratio of service unit values for beneficiaries to nonbeneficiary members would establish the proportion of covered costs applicable to Medicare beneficiaries. This method permits a more precise cost allocation because it makes allowance for the frequency and complexity of each covered service rendered.

Example

A plan has 10,000 members of which 1,000 are Medicare beneficiaries. By applying a service unit value to each covered service rendered a plan member during 1967, the plan determines that 42,000 service unit values have accrued for services rendered Medicare beneficiaries and 100,000 for nonbeneficiary members. The plan's records indicate that the cost for furnishing covered services to its members for 1967, including direct but excluding indirect administrative costs, was \$234,000. The costs applicable to Medicare beneficiaries would be determined as follows:

1. Total service unit values for covered services rendered all members	142,000
2. Total service unit values for covered services rendered Medicare beneficiaries	<u>42,000</u>
3. Total service unit values for covered services rendered non-beneficiary members (line 2 from line 1)	100,000
4. Adjustment for time factor (line 2 multiplied by 1.2)	50,400
5. Total adjusted service unit values for all members (line 4 plus line 3)	<u>150,400</u>
6. Ratio of service unit values for Medicare beneficiaries to other members (line 4 divided by line 5)	33.5%
7. Direct costs applicable to Medicare beneficiaries (Total covered costs multiplied by line 6—\$234,000 x 33.5%)	\$78,390
8. Indirect administrative expenses as in preceding Example A—(\$15,000 x 10%)	<u>1,500</u>
9. Total cost applicable to Medicare beneficiaries (line 7 plus line 8)	<u>\$79,890</u>

C. A plan may decide to determine the costs applicable to Medicare beneficiaries by determining the percentage of covered services these beneficiaries have

used compared to the services rendered persons under age 65.

1. Total covered services rendered all members are	100,000
2. Less: Total covered services rendered Medicare beneficiaries	<u>20,000</u>
3. Total covered services rendered non-medicare members (line 2 from line 1)	80,000
4. Adjustment for time factor (line 2 multiplied by Standard Factor of 20% or plan's factor of ___%)	<u>24,000</u>
5. Total adjusted covered services (line 4 plus line 3)	104,000
6. Ratio of covered services of Medicare members adjusted for time factor (line 4 divided by line 5)	23%

The percentage derived would be applied to the plan's allowable costs, excluding indirect administrative costs, to determine costs applicable to Medicare beneficiaries.

A plan could include its own time factor in lieu of the standard allowance of 20%. Such a factor would be allowable in this computation only if it were developed by comparing the average time spent in rendering covered medical services to beneficiaries age 65 and over as against the average time spent in rendering covered medical services to members under age 65.

D. If the plan has determined the utilization ratio by comparing the services used by plan members age 65 and over to the *total* numbers of services used by all plan members, (including those age 65 and over), the time factor must be developed by comparing the average amount of time required to render services to persons age 65 and over as compared to the average time required for all plan members. In such cases the

standard time factor of 20% may not be used as this standard is based on the average time spent in rendering covered medical services to Medicare beneficiaries in comparison to time spent with non-medicare members. When Medicare members are compared to the average of all members, there is already some weighting by the inclusion of Medicare members in the total.

Example

A plan, by comparing the utilization of services by Medicare beneficiaries with that of the whole plan population including Medicare members, determines that Medicare members utilize 1.5 times as many services as the average for the plan's members. The plan also determines, by comparing the physician time spent in providing services to persons age 65 and over with that of all plan members including those age 65 and over, that the aged members require 1.3 times as long to treat as the average for the plan. The plan would deter-

mine the costs applicable to Medicare enrollees as follows:

- | | |
|--|------|
| 1. Utilization factor for the elderly | 1.5 |
| 2. Time factor for the elderly | 1.3 |
| 3. Combined time and utilization factor
(line 1 multiplied by line 2) | 1.95 |

The time and utilization factors will then be applied to the plan's medical care costs which are applicable to its Medicare members.

310. "ARRANGED-FOR" SERVICES

GPPP's sometimes find it necessary to purchase some physician services on a fee-for-service basis. This may occur because needed specialist services cannot be furnished by the plan's salaried physicians, or a physician service is required by a member when he is outside the plan's service area. Reimbursement for such services may be made to the GPPP where they are furnished under an "arrangement," which is described as follows:

An *arrangement* is an agreement (either written or oral) made with a physician outside the plan, which is expected to be an on-going arrangement, entered into at a time when neither the physician nor the plan was aware that the physician's services were required to treat a specific individual. (A telephone call by the plan or the physician made at the time an individual requires medical services because of illness or injury will not meet this requirement.) The agreement must provide that the physician will treat members of the plan and spell out the basis for the amount of the plan's payment for such services. (*Note:* In the case of certain hospital-based physicians the hospital may negotiate such an arrangement. (See § 310.1).) Where laboratory or x-ray services are purchased from a certified independent laboratory or approved portable x-ray service, or are provided by a physician in his private office, such services will be deemed to be furnished under an "arrangement."

Where a plan member is referred to one of those physicians for a covered medical service, the plan may pay the physicians' fee for such service and add it to the proportionate share of other allowable costs attributed to Medicare beneficiaries. For purposes of reimbursement, a plan first determines the covered costs applicable to Medicare members for those non-fee-for-service services furnished during the year and adds to this the amount expended on behalf of Medicare members for "arranged for" services. The sum of these two amounts, less applicable deductible and coinsurance amounts, represents the plan's reimbursable costs for furnishing covered medical services to Medicare beneficiaries.

310.1 Hospital-Based Physicians.—GPPPs may make an arrangement with a hospital, or with physi-

cians in a hospital, to reimburse the professional services component of the hospital-based physician's charge. (See §§ 202.5 and 310.)

The plan is billed by the hospital or physician. The plan makes reimbursement directly to the hospital or the physician based upon the stipulated amount. It is the responsibility of the plan to make the necessary billing arrangements with the hospital and physicians. Where the hospital bills for the physician's services, the plan should also verify that the physicians have authorized the hospital to bill for them.

Costs incurred by a plan for providing covered radiological or pathological inpatient hospital services to Medicare beneficiaries should be recorded separately from the plan's other costs related to Medicare. At the end of the accounting year, such costs would be included in the plan's cost report and reimbursed 100 percent. (See § 202.7.)

At the end of the year when the plan's cost report is submitted, charges for hospital-based physician services that are included in the plan's costs will be subject to review to determine if they are reasonable in accordance with regulations. To be considered reasonable, the charge must be no greater than the reasonable charge determination that the area carrier would have made had the bill for services been submitted to the carrier for payment. If upon audit it is determined that the plan's reported allowable costs include charges for physicians' services which are greater than the reasonable charge that would be recognized by the area carrier, the plan's reported allowable costs will be adjusted accordingly.

HIR-4, Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians, explains the principles that govern the determination of reasonable charges for the services of hospital-based physicians. As explained in the introduction, where the charges for the hospital-based physicians' services to patients (as defined in Regulation 405.483) have been identified separately from charges for hospital services (as defined in Regulation 405.482), the customary charge for the physicians' service will have been established and a basis afforded for determining the reasonable charges for the services. Where, however, under existing arrangements between hospitals and physicians, billings to patients have not separately identified charges for physicians' services and charges for hospital services, it is necessary to develop an appropriate schedule of charges for Part B reimbursement purposes in accordance with the methods outlined in Reg. 405.483, 405.485 and 405.486. (A GPPP that arranges for hospital-based physicians services should obtain "reasonable charge" data from the hospital or physicians involved in the arrangement and determine if such charges have been approved by the

area carrier. Such data will enable the plan to measure the extent of allowable costs.)

In some instances a plan may arrange for the complete medical care of its plan members (including, but not limited to, those services usually rendered by hospital-based physicians) with a group of physicians who work in a hospital setting rather than in a separate clinic or office setting. In such cases the physicians or the hospital are usually reimbursed on other than a fee-for-service basis, e.g., per capita, stated amount per month, etc. The charge included in the plan's costs for such services will be considered reasonable if, in the aggregate, the amount paid did not exceed the amount that would have been paid by the program on a fee-for-service basis.

312. "NON-ARRANGED FOR" SERVICES

312.1 Conditions of Payment.—GPPP's that pay medical bills for services for which they cannot be reimbursed through their per capita payments, e.g., emergency services furnished a plan member that are provided neither by their own physicians nor suppliers nor by physicians with whom they have arrangements, may be paid directly by the Part B carriers under the following conditions:

- (a) the GPPP pays the member's bill in full;
- (b) the GPPP relieves the member of any liability (other than premium liability) for payment of the bill; and
- (c) the GPPP has the member's written authorization to receive the Part B payment.

The plan must pay any applicable deductible, the coinsurance amount, and any amount it may have to pay in excess of the "reasonable charge" as determined by the carrier. This will not prevent the plan from receiving premiums, but the plan cannot claim or receive from the enrollee (or a person responsible for the enrollee's care) any payment toward a bill for services covered by Medicare on which it claims and receives Part B benefits. It is permitted, however, to recover its expenditures (total charge minus Part B benefit), under a subrogation or nonduplication clause in its contract with the enrollee, in the event the enrollee recovers medical care costs through litigation in a personal injury action or through an insurance policy.

The plan is not bound to pay every bill of an enrollee. The plan may choose to pay only bills for specified services, and may limit its payment to bills over a certain amount (e.g., \$50). In short, the plan's own payment criteria will determine when a bill is to be paid and reimbursement sought from the Part B carrier. However, the Part B benefit due on the basis of a paid bill will be paid to the plan only if it pays in full the amount of the bill. The plan should not claim, and is not entitled to receive, the Part B benefit on any bill which it has not paid in full.

"Payment in full" does not mean that the plan must pay the bill as originally presented. If the plan can obtain the agreement of the physician or supplier to accept a lower amount as full discharge of the patient's obligation on the bill, payment of such lower amount would represent payment in full. The plan should obtain written evidence of the physician's or supplier's agreement to the reduction of the bill, e.g., a new bill or an annotation on the original bill showing acceptance of a specific lesser amount. The claim as submitted to the carrier must show clearly the amount the plan actually paid.

Whenever a Part B payment is made to a plan under this policy, an explanation of benefits will be sent by the carrier to both the plan and the enrollee.

312.2 Approval of Plan.—Plans desirous of receiving payment of Part B benefits for medical bills paid on behalf of plan members for "non-arranged" services must notify the Social Security Administration, in writing, and be assigned an identification number. The request for the assignment of such a number should be sent to the BHI regional office servicing the area in which the plan is located.

312.3 Claims for Payment.—To qualify for Part B benefits due on bills it has paid, a plan must meet the following requirements:

A. Have been found to qualify under § 312.1 above and have been assigned an identification number under § 312.2.

B. It must have available in its files the enrollee's authorization to permit the plan to be reimbursed for Part B benefits due on the basis of bills which the plan has paid in full on the enrollee's behalf. (If the enrollee is unable to execute an authorization, it may be signed on his behalf by his legal representative or, if there is none, his representative payee (i.e., a person designated by the Social Security Administration to receive monthly benefits on the patient's behalf), a close relative, or other person managing his affairs.) The following wording is suggested:

"I authorize that payment be made under Section 1842(b)(3)(B) of the Social Security Act to (name of plan) for medical and other health services furnished me for which it pays or has paid."

The authorization which the plan has in file from the plan members authorizing an exchange of information between the plan and the Administration does not meet this requirement. However, where the by-laws of the plan provide for an assignment by the enrollee to the plan, of proceeds arising to him from some other source, such provision may suffice for the required authorization. Approval from the Social Security Administration would have to be received, however,

before the conditions in the by-laws are substituted for the authorization. Where the plan must secure an authorization from the enrollee, it may do so at the time a charge is paid by the plan but before reimbursement is requested from the carrier.

C. The plan must request payment on an SSA-1490, Request for Medicare Payment (§ 499, Exhibit 2) or SSA-1490U, Request for Payment by Qualified Organizations (§ 499, Exhibit 3), submitted to the Part B carrier. The plan completes Part I of the form, which need not be signed by the enrollee. The plan should furnish sufficient itemization of the services it has paid for (with dates of service, places of service, and charges) to enable a reasonable charge determination to be made. This may be done by submitting Part II signed by the physician or an itemization on the physician's bill form.

D. Where the SSA-1490 rather than the SSA-1490U is used, a statement on the plan's letterhead should be attached to each request for payment above the signature of a responsible officer or employee of the plan, substantially as follows:

I request payment of Part B benefits on behalf of (name of plan), hereinafter referred to as 'the plan', in accordance with approval #----- I certify in connection with this request that the enrollee named above has been furnished the services described in this claim, and that:

a. the plan has paid in full the amount of the charges for the services shown on this claim;

b. the plan has the enrollee's written authorization to receive Part B benefits due on the basis of bills paid in full by the plan;

c. the plan relieves the enrollee of liability for payment for the services specified in this claim, and will not seek any reimbursement from him with respect to such services, if any Part B benefit is paid to the plan on this claim.

/s/

Title

The enrollee's name and HI number, and the current date, should be entered above the statement.

Where under this provision the plan is advised that all or a portion of the charge was used to meet the \$50 Part B deductible, the plan may include the amount thus credited toward the deductible in its care costs in determining reimbursement from SSA. Costs of such services will also be used in the computation of the weighted average deductible.

314. NONCOVERED ITEMS OR SERVICES AND NONCOVERED COSTS

Section 200 provides a list of items and services which are reimbursable under the Social Security Act. Sections 225ff. are concerned with those items and services which are not reimbursable under the Act. No plan may include in its costs expenses incurred by a Medicare beneficiary for items and services listed in § 225ff.

The administrative costs for furnishing noncovered services and those operating costs not related to patient care, e.g., expenses incurred in soliciting enrollments, etc., are not reimbursable.

Plans will also be required to reduce their total costs by such income as is realized from fees charged for rendering medical services to non-plan members, or by the cost of rendering such services if such cost is determinable. Services furnished to non-members of the plan on a fee basis are reimbursed on a reasonable charge basis through the area carrier (see § 418).

316. COMPUTATION OF THE ANNUAL DEDUCTIBLE FOR REIMBURSEMENT PURPOSES

Section 1833(b) of the Act provides that before an individual can be reimbursed under Part B for medical services, he must have incurred an annual deductible of \$50 for covered medical expenses. Accordingly, a plan which elects to be reimbursed directly by the Social Security Administration must reduce its reimbursable costs for making covered services available to Part B beneficiaries, by an amount representing the deductible.

A member of a GPPP who attains age 65 subsequent to the beginning of the plan's accounting period or who leaves the plan before the end of the year must meet the same deductible as the other members of the plan.

The Social Security Administration has determined that in a GPPP setting a 12 month fiscal period other than a calendar year can be equated to a calendar year period for the computation of the deductible and the deductible carryover. Thus a plan will determine the value of the deductible on its own fiscal year period, and it will apply the utilization of services for the last three months of its fiscal year to determine the value of the carryover. Thus, if a plan is on an April 1 through March 31 fiscal year it will compute the value of the deductible based on the experience of its plan members for that period. The value of the carryover will be based on experience for the months January, February, and March.

Because GPPP's do not ordinarily determine a cost for each service rendered an individual enrollee, a method was devised to determine an amount equivalent to each enrollee's care costs of \$50 or less during the period. The first step is to determine the average cost of a medical visit. The statistical records of the GPPP are then used to determine how many beneficiaries had no visits, how many had one visit, how many had two visits, how many had three visits, and so forth until the equivalent of visits valued at \$50 is reached, as in the following example.

245	utilized no services
100	utilized 1 service
85	utilized 2 services
67	utilized 3 services
503	utilized 4 or more services

Example

Assume that a plan has a total of 10,000 enrollees, 1,000 of whom are Medicare beneficiaries. By dividing the cost of providing covered medical visits by the total number of visits for such medical services, the plan determines that the average cost per visit, after adjustment for time factor, is \$13.50.

Based on the records of individual Medicare beneficiaries enrolled in the plan, it is determined that the following distribution of utilization occurred for the 1,000 Medicare beneficiaries.

245	x	0	x	\$13.50—\$	0
100	x	1	x	\$13.50—	1,350.00
85	x	2	x	\$13.50—	2,295.00
67	x	3	x	\$13.50—	2,713.50
503	x	\$50		—	25,150.00
					<hr/> \$31,508.50

\$31,508.50 divided by 1,000 enrollees—\$31.58, the average deductible per Medicare beneficiary.

When a plan does not have adequate records to compute the annual deductible, a standard amount will be allowed for each beneficiary. For calendar year 1966, which includes only the 6 month period from July 1—December 31, 1966, the standard deductible was established as \$23.00 per beneficiary, and for years subsequent to 1966 as \$30.00. This amount is subject to change based on information gathered as to the average value of the deductible under Medicare. Notification of such change will be sent to GPPP's at least 90 days before the close of the calendar year and will be effective the first day of the next calendar year. Plans having a high percentage of welfare beneficiaries in their age 65 and over population, will not be permitted to use the standard deductible allowance without prior authorization from the Social Security Administration.

316.1 Computation of the Carryover Deductible.—Expenses incurred in the last three months of the previous year *which were applied toward the deductible for that year* may also be applied against the deductible for the current year.

A GPPP which computes its own deductible may reduce its computed deductible by an amount representing the average carryover of its Medicare members. The amount of the carryover should be based on the number of medical visits per beneficiary made during the last three months of the previous year which would have been applied toward the deductible.

The amount of the carryover means the amount incurred per beneficiary during the last three months which, when added to the amount incurred during the first nine months, would equal \$50.00 or less for the year. The amount would be computed on the basis of the average cost per visit for that year. Only the amount incurred during the last three months is taken into account. The date of service determines when the expenses were incurred.

A plan may use any method to compute the carryover which best suits its operations provided such method produces acceptable results. If the number of Medicare beneficiaries enrolled in the plan is too large to include all beneficiaries in the computation, the plan may propose the use of a statistical sample which would be subject to review and approval by SSA.

318. PRO-RATA DEDUCTIBLE FOR BENEFICIARY RECORD

Each Part A beneficiary enrolled in a direct dealing GPPP is responsible for a proportionate share of those covered costs not reimbursed the plan because of the Medicare deductible and coinsurance. That portion of the monthly premium which a beneficiary pays (or has paid on his behalf) to the plan to cover the cost of the deductible and coinsurance will be credited toward the individual's Part B deductible record. This figure has significance only when a plan member receives services outside the plan. In that case, the accumulated amount credited to the enrollee's deductible record will determine his deductible status for reimbursement for the services received outside the plan.

The monthly credit for the deductible amount will normally bear a relationship to the weighted average deductible which the plan has determined to be applicable in its reimbursement formula. Thus, in determining the monthly amount to be credited to the enrollee a plan may apply one-twelfth of the weighted average deductible plus the coinsurance amount. The coinsurance amount is limited by law to twenty percent of the plan's covered care costs. For example, a plan which computes its covered care cost for the year to be \$80 for each enrollee and determines its weighted average annual deductible to be \$30 may determine the pro-rata monthly amount as follows:

1/12 of the average monthly deductible (\$30 ÷ 12)	\$2.50
20% of the monthly charge for the co- insurance ($\$80 - \$30 = \$50.00$; 1/12 of \$50 = 4.16; 20% of \$4.16 = Total)	.83
	<hr/> <u>\$3.33</u>

The monthly amount to be credited to the enrollee as representing the deductible for medical covered services received outside the plan would therefore be \$3.33 (\$2.50 + .83).

There may be other methods which the plan may use in computing the monthly amount to be credited to the enrollee's deductible. In such cases the plan must notify the Social Security Administration of its basis for determining the monthly deductible. The aggregate of the deductible and coinsurance which the plan credits its enrollees cannot exceed the total cost to the plan of the deductible and coinsurance for these individuals.

Whenever plans change their premium rates, the change generally should be accompanied by a change in the pro-rata amount which would be credited to each member-beneficiary's deductible account. However, it would not be feasible to record individual pro-rata changes at the time of each specific premium change.

Changes in a plan's pro-rata amount will be entered into Social Security records only on January 1 of *each calendar year* and will not be changed during that year.

In order to change the pro-rata amount on January 1, of any calendar year, the proposed change must be submitted, in writing, no later than November 15 of the year prior to the year in which the change is to become effective. This notification should be sent to:

Social Security Administration
Bureau of Health Insurance
Division of Systems
Baltimore, Maryland 21235

In the event a plan does not submit a new pro-rata amount to be credited to its member-beneficiaries' deductible accounts by November 15 of each year, the pro-rata amount for the following calendar year will remain the same as the previous calendar year.

320. LIMITATION TO PREMIUM RATE ASSESSMENTS

Section 1833(a)(1) of the law provides that a GPPP that elects reasonable cost reimbursement may not charge its members who are Part B beneficiaries more than 20 percent of the reasonable cost of covered services plus the amount payable to meet the Part B annual deductible.

A cost reimbursement plan is required to agree, in writing, that:

a. the plan will notify the Social Security Administration, within 30 days after its accounting year begins, of the amounts that represent the Part B deductible and the 20 percent coinsurance which are included in the total monthly premium assessment to the members who are Part B beneficiaries;

b. plan member beneficiaries will be charged no more than 20 percent of the reasonable cost of Part B services plus such amounts as may be payable to accommodate the Part B deductible. This includes any amounts charged as a registration, or similar fee when a person makes a visit to a plan physician as well as premium payments made by or on behalf of the individual;

c. the plan will maintain adequate accounting records as to the cost of services provided and that such records will be available for examination and audit by SSA, the General Accounting Office, or their representatives;

d. the plan will refund or dispense any monies incorrectly collected from member beneficiaries. In lieu of a cash refund the plan may reduce the premium amounts charged this group for the subsequent year or provide additional services to the group for the same premium as before. The additional services provided or the premium reduction made to the group must closely approximate the amount incorrectly collected.

322. PROVIDER SERVICES

Some GPPP's own and operate their own provider facilities, i.e., hospital, extended care facility, or home health agency, which furnish covered provider services to its members. Other plans have arrangements with such providers to furnish care to their enrollees with the plan paying for the cost of such care on a contract basis.

Where the plan owns and operates one or more of these facilities which has entered into an agreement

with the Secretary to participate in Medicare, reimbursement to the plan for care provided to beneficiary enrollees will be determined under the same principles applicable to all other providers of services. The costs of such services must be computed and reimbursed separately from the plan's per capita reimbursement for Part B medical services.

Where the plan has an arrangement with a provider of services participating in Medicare, the provider, and not the plan, will be reimbursed for provider services rendered to plan members.

324. OUTPATIENT PSYCHIATRIC SERVICES

The limitation on outpatient psychiatric services means that (1) benefit payments for services are subject to a limitation of 50 percent (80% of $62\frac{1}{2}\%$ = 50%) of incurred expenses above the deductible, and (2) no more than \$250 (80% of \$312.50) may be paid on behalf of an individual during a calendar year. The limitation applies only to charges for physicians' services. Expenses attributable to the services of a psychologist or other nonphysician personnel are not subject to this limitation. (See § 255ff.)

GPPP's that furnish outpatient psychiatric services will be reimbursed by *the area carrier* for the physician's component of such services. Other costs connected with the rendering of such care will be included in the plans' care costs subject to cost reimbursement.

Following is a suggested method to determine an average cost per psychiatric visit in reporting these services to the area carrier. The method outlined for determining an average cost per visit may not be applicable to all plans. Plans may, therefore, propose other methods of determining reimbursement for the carrier's approval, provided the method proposed yields comparable results. Each plan is required to submit to its area carrier for approval, the cost per visit it has determined and the method used to determine that amount. These instructions apply to all outpatient psy-

chiatric visits made by Medicare plan members on and after July 1, 1966. The cost per visit reported to the area carrier should be based on the plan costs in the accounting year in which the visit took place, i.e., plans using a calendar year for accounting purposes should determine a cost per visit for 1966 and one for 1967 and subsequent years based on the costs for each of these years.

The area carrier for each plan will be the carrier servicing the area in which the plan's headquarters is located.

A. Estimated Average Cost Per Visit for Psychiatric Services.—

An estimated average cost per visit may be determined by dividing the estimated physician cost of providing outpatient psychiatric visits by the estimated total number of outpatient psychiatric visits which will be rendered by the plan, adjusted to reflect the additional time required to treat patients age 65 and over. This becomes the estimated average cost per visit to be applied to all outpatient psychiatric visits rendered by the plan to beneficiary-enrollees.

The term "visit" refers to a face-to-face visit with a plan physician either on an appointment or non-appointment basis for examination and/or treatment.

Example: A plan's costs for the year 1968 for providing outpatient psychiatric services to all of its enrollees was \$8,750, of which \$4,350 represented physician salaries. During the same period there were 950 outpatient psychiatric visits of which 95 (10%) were for individuals age 65 and over. The plan estimates that in 1969 its costs will increase to \$9,000 with physician salaries representing one-half (\$4,500) of this amount. The plan also estimates that the number of outpatient psychiatric visits will increase to 1,000 with 10 percent being used by persons age 65 and over.

The estimated average cost per outpatient psychiatric visit would be determined by the following computation:

Estimated number of outpatient psychiatric visits provided to plan members and nonmembers age 65 and over	100
Adjusted for time factor (100 x 1.2)	120
Estimated number of outpatient psychiatric visits provided to other individuals under age 65	900
Total number of estimated outpatient psychiatric visits (adjusted for time factor)	1,020
Total Estimated Costs of Physicians for Outpatient Psychiatric Visits (\$4,500)	
Total Estimated Number of Outpatient Psychiatric Visits (1,020)	
Average charge per outpatient psychiatric visit, \$4.41.	
Adjusted average charge per outpatient psychiatric visit for persons age 65 and over \$4.41 x 1.2 (allowance for time factor) =	\$5.29.

(Since the limitation applies to any physician who treats a mental, psychoneurotic, or personality disorder, whether or not the physician is a psychiatrist, it may be necessary for the plan to allocate a portion of such physicians' salaries to the costs used to compute the average cost per visit. This would be done by allocating an appropriate part of salaries based on the percentage of time the physicians devote to psychiatric visits.)

If a plan is unable to separate the physician's compensation from the total cost of providing psychiatric services, it may determine the "average charge per outpatient visit" on the basis of total costs. Thus, in the above example, the total cost of \$9,000 would be divided by the number of adjusted visits (visits times 1.2) and the resulting amount multiplied by 1.2 to arrive at the charge per visit. Fee-for-service payments made to psychiatrists on an "arranged for" basis should not be included in the plan's estimated cost of providing outpatient psychiatric services. Plans should submit receipted bills to the area carrier with a form SSA-1490 to show the organization requesting reimbursement. (See § 312.)

Where a plan psychiatrist or other physician providing psychiatric services spends a portion of his time in administrative duties or in consultation with other plan physicians not involving seeing the patient, his entire salary need not be included in the above calculation. The plan may instead allocate the psychiatrist's salary on the basis of the percentage of time spent in face to face contact with patients and that spent in administrative or consultative functions. That portion applicable to face to face contacts will be included in determining the average cost of an outpatient psychiatric visit. The portion applicable to administrative and consultative functions will be included in the plan's total care costs. However, where the consultation results in the other physician treating the patient for a mental, psychoneurotic, or personality disorder, it will be necessary to allocate a portion of the other physician's salary to the cost on which the average cost for such visits will be based.

B. Request for Payment—

The plan will prepare a Request for Payment Form SSA-1490 and send it to the area carrier. The enrolled beneficiary's signature will not be required on the form SSA-1490. In Column E, Part II under Charges, the plan should enter its charge for each outpatient psychiatric visit. The full amount determined by the plan to be the physician's component per visit, should be entered for each visit provided. Where a plan is unable to determine the physician's component per visit, it should use the entire adjusted average charge as the charge per visit. The forms SSA-1490 sent to the area carrier should be stamped "GPPP OUTPA-

TIENT PSYCHIATRIC SERVICES" to assist the carrier.

Plans will be expected to report psychiatric services on forms SSA-1590, Group Practice Plan Utilization Listing of Social Security Medical Insurance Services (§ 399, Exhibit 3), and SSA-1591, Group Practice Plan Individual Patient Utilization Report of Social Security Medical Insurance Services, (§ 399, Exhibit 4), that the plans normally use even though they also send an SSA-1490 to the area carrier.

When a plan is notified that a beneficiary enrollee has reached the limit on reimbursement for outpatient psychiatric services, it will not be necessary to continue reporting additional visits of this type since no additional reimbursement can be made by the area carrier. The costs for such visits, however, should be allocated to the appropriate cost accounts established to record the costs of such outpatient psychiatric visits.

C. Deductible Met.—The area carrier will make payment provided the beneficiary involved has met the annual \$50 deductible and has not exceeded the limitation on these services. Since the payments are made through the area carrier on a "reasonable charge" basis, there will be no retroactive adjustment.

D. Deductible Not Met.—If the beneficiary has not met his \$50 deductible, the plan may include in its costs 62.5 percent of the amount which goes toward the \$50 deductible.

E. Recording Psychiatric Services Costs.—Plans reporting a total departmental charge per visit should record in separate accounts, all costs of providing outpatient psychiatric services and the amount of reimbursement received from the area carrier. The costs should not be included in determining the interim per capita payments or in the total care costs for the year. Reimbursement received from the carrier will not be used to reduce the total care costs.

Plans reporting only the physician's component as the charge per outpatient psychiatric visit should maintain two separate cost accounts, one to record the cost of physician salaries, and another to record all the other costs of providing outpatient psychiatric services. In addition, plans should maintain a separate record of the amounts reimbursed by the carrier for these outpatient psychiatric services.

The plan's costs, other than physician salaries, attributable to providing outpatient psychiatric services are includable in the plan's care costs for purposes of determining both interim per capita payments and total care costs for the year. Reimbursement from the carrier will not be used to reduce the total care costs.

326. REIMBURSEMENT OF CIVIL SERVICE ANNUITANTS

After enactment of the Medicare program, most

GPPP's modified their benefits and/or premium rates for people 65 and over to take account of the increased protection Medicare beneficiaries have. However, plans operating under the Federal Employees Health Benefits Act of 1959 (FEHBA) are unable, under that law, to adjust their rates similarly for civil service annuitants. Therefore, the annuitants covered by both the 1959 Act and supplementary medical insurance (SMI), unlike members of all other GPPP's, do not receive protection equivalent to their combined SMI and FEHBA premiums.

Under the Social Security Amendments of 1967, FEHBA plans may reimburse members enrolled for Part B up to the full amount of their Part B premiums, provided such reimbursement is financed from funds other than the contributions made by the Government and the annuitants toward the FEHBA plan (Section 166 of the Social Security Amendments of 1967). (These refunds are not reimbursable cost items and should not be included in operating costs under Medicare.) Such Part B premium refunds can and should be made out of funds received under Part A or Part B of title XVIII.

328. FILING FINAL COST REPORTS

Until plans are notified to use a specific cost reporting form, they will be permitted to file cost reports in any format which will suit their operation. Reports should be submitted to the Social Security Administration no later than 120 days after the expiration of the plan's *accounting* year.

Plans, in filing their cost report forms, should remember that the following information is required for a final cost adjustment:

1. Costs per plan accounting records.
2. Details on adjustments to these costs for expenses not reimbursable under the law such as advertising and membership enrollment and for the costs of services not covered under the law. (See § 314.)
3. Schedules of those administrative costs not related to patient care, e.g., administrator's salary, accounting fees, etc. (See § 306.4.)
4. Computation of the "Allowance in Lieu of Specific Recognition of Other Costs". (See § 365.)
5. Schedules of the salaries of physicians who provide outpatient psychiatric services. (See § 324.)
6. Details as to the method of allocating total costs between Medicare and non-Medicare members, showing the basis for time and utilization factors used. (See § 308.)
7. Details regarding the computation of the deductible if the standard deductible amount is not used. (See § 316.)
8. Either the total membership months for Medi-

care enrollees who were plan members or the average number of Medicare members per month.

Policies and Guidelines on Costs

335. COSTS

The following sections provide guidelines and policies to be followed in regard to specific items of cost. For any cost situation that is not covered by these guidelines and policies, generally accepted accounting principles should be applied.

Under generally accepted accounting principles, there may be more than one method for handling a particular cost item; the method elected by the GPPP must be consistently followed in subsequent reporting periods. A change of method must have advance approval from the SSA. The request should be made before the end of the first month of the accounting year in which the new method is to be employed. Where these instructions set a time limit for requesting a change, or limit the number of changes, the GPPP will be guided by the instructions.

If a GPPP has any question on how to determine cost, or how to apply these guidelines in a particular situation, it should submit the question to the SSA, Bureau of Health Insurance, Division of Reimbursement, Baltimore, Maryland 21235.

336. DEPRECIATION

Depreciation is that amount which represents a portion of the depreciable asset's cost or other basis which is allocable to a period of operation. The amount of depreciation is determined by the plan's method of depreciation accounting.

The American Institute of Certified Public Accountants defines depreciation (as a process of cost allocation):

"Depreciation accounting is a system of accounting which aims to distribute the cost or other basic value of tangible capital assets, less salvage (if any), over the estimated useful life of the unit (which may be a group of assets) in a systematic and rational manner. It is a process of allocation, not of valuation. Depreciation for the year is the portion of the total charge under such a system that is allocated to the year."

The guidelines for reimbursement for GPPP costs provide that payment for services should include depreciation on all depreciable assets that are used to provide covered services to beneficiaries. This includes assets that may have been fully (or partially) depreciated on the books of the GPPP but are in use at the time the GPPP enters the program. The useful lives of such assets are considered not to have ended and depreciation calculated on a revised extended useful life is allowable. Likewise, a depreciation allowance is permitted on assets that are used in a normal standby or emergency capacity.

Three methods of prorating the cost of depreciable assets over the estimated useful life are available: straight-line, declining balance, and sum-of-the-years' digits (§ 347). The method chosen for the Medicare program for an asset or groups of assets need not correspond to the methods used by the GPPP for non-Medicare reporting purposes.

An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be: (1) identifiable and recorded in the GPPP's accounting records (§ 337); (2) based on the historical cost of the asset or fair market value at the time of donation in the case of donated assets (§ 338); and (3) prorated over the estimated useful life of the asset using the straight-line method or accelerated depreciation under declining balance or sum-of-the-years' digits methods (§ 340).

Depreciation on assets being used by a GPPP at the time it enters into the Medicare program is allowed; this applies even though such assets may be fully or partially depreciated on the plan's books.

With respect to all assets acquired before 1966, the GPPP, at its option, may choose an allowance for depreciation based on a percentage of operating costs. The operating costs to be used are the lower of the GPPP's 1965 operating costs or the GPPP's current year's allowable costs. The percent to be applied is 5 percent starting with the year 1966–1967, with such percentage being uniformly reduced by one-half percent each succeeding year. The allowance based on operating costs is in addition to regular depreciation on assets acquired after 1965; however, when the optional allowance is selected, the combined amount of such allowance on pre-1966 assets and the straight-line depreciation on assets acquired or rented after 1965 may not exceed 6 percent of the GPPP's allowable cost for the current year. Depreciation is also allowed on assets financed with Hill-Burton or other Federal or public funds.

336.1 Depreciable Assets.—Assets in which a GPPP has an economic interest through ownership (for exception see § 345 “Allowance for Depreciation on Facilities Leased for a Nominal Amount”)—regardless of the manner in which they were acquired—are subject to depreciation. Generally, depreciation is allowable on the assets described below when they are used in the regular course of providing medical care. Assets which a GPPP uses under a regular lease arrangement are not subject to depreciation by the plan. (See § 338.4 “Lease Purchase Assets.”)

336.2 Building.—Includes, in a restrictive sense, the basic structure or shell and additions thereto. The remainder is identified as building equipment.

336.3 Building Equipment.—Includes attachments to buildings, such as wiring, electrical fixtures,

plumbing, elevators, heating systems, air conditioning system, etc. The general characteristics of this equipment are: (1) affixed to the building and not subject to transfer, and (2) a fairly long life, but shorter than the life of the building to which affixed. Since the useful life of such equipment is shorter than that of the building, the equipment cost may be separated from building cost and depreciated over the shorter useful life.

336.4 Major Movable Equipment.—Includes such items as accounting machines, beds, wheelchairs, desks, vehicles, x-ray machines, etc. The general characteristics of this equipment are: (1) a relatively fixed location in the building, (2) capable of being moved as distinguished from building equipment, (3) a unit cost sufficient to justify ledger control, (4) sufficient size and identity to make control feasible by means of identification tags, and (5) a minimum expected useful life of approximately three years.

336.5 Minor Equipment.—Includes such items as waste baskets, syringes, catheters, mops, buckets, etc. The general characteristics of this equipment are: (1) in general, no fixed location and subject to use by various departments, (2) comparatively small in size and unit cost, (3) subject to inventory control, (4) fairly large quantity in use, and (5) generally, a useful life of approximately three years or less.

336.6 Land (Non-Depreciable).—Includes the land owned and used in GPPP operations. Included in the cost of land are the costs of such items as off-site sewer and water lines, public utility charges necessary to service the land, governmental assessments for street paving and sewers, the cost of permanent roadways and grading of a non-depreciable nature, the cost of curbs and sidewalks whose replacement is not the responsibility of the GPPP, and other land expenditures of a non-depreciable nature.

336.7 Land Improvements (Depreciable).—Includes paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc. (if replacement is the responsibility of the GPPP).

336.8 Leasehold Improvements.—Includes betterments and additions made by the lessee to the leased property. Such improvements become the property of the lessor after the expiration of the lease.

337. DEPRECIATION-ACCOUNTING RECORDS

The depreciation allowance, to be acceptable, must be adequately supported by the plan's accounting records. For Medicare purposes a plan may maintain supplementary records apart from formal records but in a manner similar to that used in maintaining formal

records. Appropriate recording of depreciation requires the identification of the depreciable assets in use, the assets' historical costs (or fair market value at the time of donation in the cases of donated assets), the method of depreciation, and the assets' accumulated depreciation.

338. DEPRECIATION-HISTORICAL COST

338.1 Actual Cost.—Historical cost is the cost incurred by the present owner in acquiring the asset and preparing it for use. Such cost includes those costs that would be capitalized under generally accepted accounting principles. For example, in addition to the purchase price, historical cost would include architectural fees, consulting fees, related legal fees, interest cost during construction, etc.

338.2 Trade Ins.—When an asset is acquired by trading in an asset that was depreciated under the program, the cost of the new asset would be the sum of the undepreciated balance of the old asset and the cash paid or to be paid. Where the old asset was acquired by the GPPP before entrance into the program, and the sum of the undepreciated balance and the cost paid or to be paid exceeds the list price, the cost of the new asset will be the list price.

338.3 Appraisals.—Where historical cost records of a purchased asset are not available an appraisal made by a recognized expert to establish the historical cost of the asset will be acceptable for depreciation purposes. Before an appraisal is made the GPPP should inform the Social Security Administration, Division of Reimbursement, Bureau of Health Insurance, of the appraisal expert and the type and method of appraisal to be used. The Administration will determine whether the contemplated appraisal will be acceptable. The appraisal to establish the historical cost of assets should produce a value approximating the cost of reproducing substantially identical assets of like type, quality, and quantity at a price level in a bona fide market as of the date of acquisition. The appraisal expert should be one who is recognized as an appraisal authority based on sufficient experience and background in determining the historical cost of used assets.

338.4 Lease-Purchase Assets.—The historical cost of such assets is the sum of the lease payments and any additional payments made to acquire the assets, excluding the amount allowed as rent during the period of the lease or rental arrangement.

338.5 Purchase of a GPPP as an On-Going Operation.—In establishing the historical cost of assets where an on going GPPP is purchased through a bona fide sale after June 30, 1966, the sale price or portion thereof attributable to the asset must not exceed the fair market value of the asset at the time of sale. If the facility was being operated under the program at the

time of sale, the sale price used by the seller in computing gain or loss for the final cost report, must agree with the historical cost used by the new GPPP in computing depreciation.

If a purchaser cannot demonstrate that the sale was bona fide, the lesser of the seller's net book value or sale price will be used by the purchaser as the historical cost of the asset. In such cases, the difference between the sale price and the net book value shall be considered goodwill. The goodwill so established is not amortizable.

339. FAIR MARKET VALUE—DONATED ASSETS

Fair market value is the price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition. Usually the fair market price will be the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition. An asset is considered to be donated when the GPPP acquires the asset without making any payment for it in the form of cash, property, or services. When the GPPP makes any payment in acquiring the asset in a bona fide transaction then this payment, and not the fair market value, is considered to be the historical cost of the asset.

Where the GPPP's records do not contain the fair market value of the donated assets as of the date of donation, an appraisal of such fair market value by a recognized appraisal expert will be acceptable for depreciation purposes. (See § 338.3.)

340. USEFUL LIFE OF DEPRECIABLE ASSETS

The depreciable life of an asset is its expected useful life to the GPPP, not necessarily the inherent useful or physical life. The useful life is determined in the light of the GPPP's experience, the general nature of the asset, and other pertinent data. Some factors for consideration are: (1) normal wear and tear, (2) obsolescence due to normal economic and technological advances, (3) climatic and other local conditions, and (4) the GPPP's policy for repairs and replacement and expected or known retirement date.

GPPP's may use the useful life guidelines published by the American Hospital Association or the Internal Revenue Service. A different life may be used; however, when the life selected differs significantly from that established by the guides it must be supported by adequate documentation. In addition, a composite useful life may be used for a class or group of assets.

340.1 Leasehold Improvements.—The cost of improvements which are the responsibility of the GPPP under the terms of a lease may be depreciated over the useful life of the improvement or the remaining term

newed, extended, or continued following either an option exercised by the GPPP or, in the absence of an of the lease, whichever is shorter. The term of the lease includes any period for which the lease may be re-option, reasonable interpretation of past acts of the lessor and lessee pertaining to renewal, etc., unless the GPPP establishes, omitting past acts, that it will probably not renew, extend, or continue the lease.

341. SALVAGE VALUE

Salvage value is the estimated amount expected to be realized upon the sale or other disposition of the depreciable asset when it is no longer useful to the GPPP. The amount is ordinarily estimated at the time of acquisition and except for the declining balance method, is deducted from the cost of the depreciable property to arrive at the basis for depreciation. For example, an asset is purchased for \$17,000 with an expected salvage value of \$2,000; the basis for depreciation becomes \$15,000—i.e., \$17,000 less \$2,000—for computing the depreciation.

Thus, if a GPPP disposes of assets which are in good operating condition, the salvage value might be higher than if the GPPP used the assets until their inherent life had been substantially exhausted.

342. METHODS FOR WRITING OFF COST OF MINOR EQUIPMENT

The original cost of minor equipment may be treated in any of the following methods:

(a) The original investment in this equipment is not amortized or depreciated. Any replacements are charged to operating expense. The investment in non-amortizable equipment is adjusted periodically by increases; or

(b) The inventory cost of such items at the time the GPPP enters the program is written off ratably over 3 years, that is $\frac{1}{3}$ of the inventory cost is written off each year. Any new purchase will also be written off ratably over a 3-year period; or

(c) Certain categories of equipment such as, for example, small tools, are written off ratably over their actual useful lives.

343. CAPITALIZATION OF EXPENDITURES FOR DEPRECIABLE ASSETS

Realistic standards must be set by GPPP's in establishing the cost and useful lives of depreciable assets purchased which will be capitalized. For example, the policy of a particular GPPP may be to capitalize all depreciable asset expenditures of \$50 or more when the asset has an estimated useful life of three years or longer, while asset expenditures of less than \$50 would be charged to expense. The standards so established must be followed consistently. Irrespective of the plan's established policy, however, depreciable assets costing

\$100 or more must be capitalized. Where an asset is purchased in quantity so that the cost of the quantity exceeds \$200, the cost of the individual items must be capitalized.

344. SALE AND LEASEBACK-AND-LEASE PURCHASE ARRANGEMENTS

344.1 Sale and Leaseback Agreements—Rental Charges.—Rental costs specified in sale and leaseback agreements, incurred by GPPP's through selling plant facilities or equipment to a purchaser not connected with or related to the GPPP, and concurrently leasing back the same facilities or equipment are includable in allowable costs if the following conditions are met:

(a) The rental charges are reasonable based on consideration of rental charges of comparable facilities and market conditions in the area, the type, expected life, condition, and value of the facilities or equipment rented and other provisions of the rental agreement.

(b) Adequate alternate facilities or equipment which would serve the purpose are not or were not available at lower cost.

(c) The leasing was based on economic and technical considerations.

If all these conditions are not met, the rental charge cannot exceed the amount which the GPPP would have included in reimbursable costs had the plan retained legal title to the facilities or equipment, such as interest on mortgage, taxes, depreciation, insurance, and maintenance costs.

344.2 Lease Purchase Agreements—Rental Charges.—Some lease agreements are essentially the same as installment purchases of facilities or equipment. If the lease is a virtual purchase, the rental charge is includable in allowable costs only to the extent that it does not exceed the amount that the GPPP would have included in allowable cost had the plan had legal title to the asset, such as, for example, straight-line depreciation, insurance, and interest. The difference between the amount of rent paid and the amount of rent allowed as rental expense is considered a deferred charge and is capitalized as part of the historical cost of the asset when the asset is purchased. If the asset is returned to the owner, instead of being purchased, the deferred charge may be shown to be an expense in the year of the asset's return. If the asset continues to be rented after the due date for the purchase, and rental has been reduced, the deferred charge may be shown to be an expense to the extent of increasing the reduced rental to a fair market rental value.

The existence of the following conditions will generally establish that a lease is a virtual purchase: (1) the rental charge exceeds rental charges of comparable facilities or equipment in the area, and (2) the term of

the lease is less than the useful life of the facilities or equipment, and (3) the GPPP has the option to renew the lease at a significantly reduced rental, or the GPPP has the right to purchase the facilities or equipment at a price which appears to be significantly less than what the fair market value of the facilities or equipment would be at the time of acquisition by the GPPP is permitted.

345. ALLOWANCE FOR DEPRECIATION ON FACILITIES LEASED FOR A NOMINAL AMOUNT

Some plans may lease their facilities at a nominal rental—usually \$1.00 per year; the lease generally covers the useful life of the facility. Under most such lease arrangements the tenant (lessee) maintains the property and pays the cost of any improvement or addition to the facility. When such improvement or addition is made the lessee may properly amortize the cost. The amortization allowance is includable in allowable cost. At the end of the lease, improvements and additions made by the lessee become the property of the lessor. However, in some instances the lease arrangement provides that title to any additions or improvements is to revert to the owner in the first year they are used. In such cases the cost of any addition or improvement would be similarly amortized and the amortization allowance would likewise be includable in allowable cost.

It is the general practice of the plan to include in its charges (and cost) an amount to cover depreciation on the leased facilities as distinguished from capital improvements made by the lessee. In view of the above and since the lease arrangement in such cases generally contemplates the occupancy by the lessee for the period of the useful life of the facility, depreciation on the leased facility may be included in allowable cost under the conditions described below.

345.1 Analysis of Lease Arrangement.—Each case must be decided on its own merits for depreciation to be allowed. The lease must contemplate that the lessee will make any necessary improvements and will properly maintain the facility.

The lease may and frequently does cover the useful life of the asset; however, if the lease does not do so, such as a year-to-year lease, it should be examined closely to determine whether the renewal and other provisions of the lease contemplate that the GPPP will use the facilities to the extent of their useful lives. Where the intent and provisions of the year-to-year lease permit the plan to have the benefit of the useful life of the facility, such lease should be treated, for

depreciation purposes, in the same manner as a long-term lease that covers the useful life of the asset. The actions of the lessee and lessor in such cases should indicate that the intent of both parties is to continue the lease arrangements for the useful life of the asset. Of course, other known facts should be considered together with the past actions of the lessee and lessor in order to determine whether or not the asset will and can be used by the lessee for the asset's full useful life.

The lease should have no restrictions on the free use of the facility by the lessee. In addition, the lease should not provide for any indirect benefits to the lessor or to those connected with the lessor. For example, if the lease requires that the lessee furnish free medical services to the employees of the lessor, then depreciation in such case should not be allowed. In such cases the cost of the services furnished to the lessor's employees would be appropriately included when determining Medicare's share of allowable costs.

Where the plan pays or contributes to the lessor any funds which are to be used for retiring the lessor's bonds or notes issued for the facility, such payments will be considered rental payments. These rental payments, to the extent they are reasonable, will be considered an allowable cost; likewise, any general contribution to the lessor by the lessee will be considered a rental payment for the use of the facility. Where either of such rental payments is allowable as cost, depreciation on the leased facility will not be an allowable cost item.

Any questions on the legal interpretation of the lease as it relates to the criteria discussed above, should be submitted to the Bureau of Health Insurance regional office for an opinion from the regional attorney.

345.2 Basis and Method for Depreciation.—The leased asset should be treated for depreciation cost allowance purposes under the program as though the lessor and lessee were one and the same. All the sections on depreciation would be applicable to such assets. For example, the basis for depreciation will be the historical cost of the asset to the lessor adjusted for past depreciation, and if historical cost records are not available, a proper appraisal for establishing the historical cost would be acceptable. Where the leased facility is later purchased by the plan, the facility's undepreciated balance on the date of title transfer or the purchase price, whichever is lower, will for further depreciation purposes be considered the unrecovered cost of the facility.

The following illustration demonstrates how depreciation would be computed on the leased facility and amortization on improvements made to that facility.

FACTS

Historical cost of the leased facility at acquisition date—7/1/56	\$520,000
Estimated Salvage Value	20,000
Estimated Useful Life of the Facility	40 years
Life of the Lease Effective at 7/1/60	35 years
Method for Depreciation	Straight-line
Leasehold Improvement—7/1/65	\$ 90,000
Estimated Useful Life of Improvement	30 years

COMPUTATION OF DEPRECIATION

Historical Cost of Building	\$520,000	
Less: Estimated Salvage Value	20,000	
Basis for Depreciation	\$500,000	
Annual Rate of Depreciation based on 40-year Life	2.5%	
Annual Depreciation on Building		\$ 12,500
Accumulated Depreciation on 7/1/66 (date of entry into Medicare program) (10 years @ \$12,500)		\$125,000

COMPUTATION OF AMORTIZATION ON IMPROVEMENT

Cost of Leasehold Improvement	\$90,000	
Useful Life	30 years	
Annual Amortization	\$90,000	30 years
Accumulated Amortization on 7/1/66		\$ 3,000

TOTAL ANNUAL DEPRECIATION AND AMORTIZATION

Annual Depreciation on Facility	\$ 12,500
Annual Amortization on Improvement	3,000
Total	\$ 15,500

346. BASIS FOR DEPRECIATION

346.1 New Assets.—The basis for depreciation of new assets under the straight-line and sum-of-the-years' digits methods is the historical cost of the asset (or fair market value in the case of donated assets) less its salvage value. Under the declining balance method, the basis for depreciation is the historical cost only.

346.2 Used Assets—Partially or Fully Depreciated on the GPPP's Books.—The adjusted historical cost of the asset as determined below is to be used for determining the basis for depreciation under the three approved methods for depreciation. For the straight-line and sum-of-the-years' digits methods, the basis for depreciation would be the adjusted historical cost reduced by the estimated salvage value. Where the declining balance method is used, the basis for depreciation would be the adjusted cost of the asset.

The adjusted historical cost of an asset that is in use when the GPPP enters the program is its historical cost reduced by the depreciation accumulated up to the date of entrance into the program. Accumulated depreciation for this purpose may be determined on a straight-line basis—regardless of the depreciation

method used or in use by the GPPP—and based on an estimate of the asset's useful life taking into account past and current information. Thus, if an asset currently in use has been fully depreciated on the GPPP's books it would be evident that an asset's useful life has not ended. Consequently, a new estimate if the asset's useful life, based on current information and subject to approval by the SSA may be made. The following examples illustrate how the basis for depreciation is determined for used assets:

FACTS

1. Historical cost of the asset	\$25,600
2. Estimated salvage value	1,600
3. Asset acquired on July 1, 1962	
4. Original estimated useful life is 8 years	
5. On July 1, 1966, the asset's useful life is estimated to be 12 years from date of acquisition	
(a) GPPP previously used straight-line method for depreciation—Assets partially depreciated	
Accumulated depreciation on the books	\$12,000
Accumulated Depreciation for Medicare purposes	
Historical cost	\$25,600

Estimated salvage value	1,600
Basis for computing accumulated depreciation	<u>\$24,000</u>
Adjusted accumulated depreciation (4/12 x \$24,000)	<u>\$ 8,000</u>
Adjusted historical cost:	
Historical cost	\$25,600
Less: adjusted accumulated depreciation	8,000
Adjusted historical cost	<u>\$17,600</u>
Basis for depreciation under the program:	
Declining balance method of depreciation (Adjusted historical cost)	<u>\$17,600</u>
Straight-line and sum-of-years' digits methods: (Adjusted historical cost)	<u>\$17,600</u>
Less: estimated salvage value	1,600
Basis for Depreciation	<u>\$16,000</u>
(b) <i>GPPP previously used sum-of-the-years' digits for depreciation—Asset partially depreciated</i>	
Accumulated depreciation on the books	<u>\$17,333</u>
Accumulated depreciation for Medicare purposes:	
Historical cost	\$25,600
Estimated salvage value	1,600
Basis for computing accumulated depreciation	<u>\$24,000</u>
Adjusted accumulated depreciation, using the straight-line method for depreciation (4/12 x \$24,000)	<u>8,000</u>
Adjusted historical cost:	
Historical cost	\$25,600
Less: adjusted accumulated depreciation	8,000
Adjusted historical cost	<u>\$17,600</u>
Basis for Depreciation under the program:	
Declining balance method (Adjusted historical cost)	<u>\$17,600</u>
Straight-line and sum-of-the-years' digits methods: (Adjusted historical cost)	<u>\$17,600</u>
Less: estimated salvage value	1,600
Basis for depreciation	<u>\$16,000</u>
(c) <i>GPPP previously used declining balance method—Asset partially depreciated</i>	
Accumulated depreciation on the books	<u>\$17,500</u>
Accumulated depreciation for Medicare purposes:	
Historical cost	\$25,600
Estimated salvage value	1,600
Basis for computing accumulated depreciation	<u>\$24,000</u>
Adjusted accumulated depreciation, using the straight-line method for depreciation (4/12 x \$24,000)	<u>\$ 8,000</u>

Adjusted historical cost:	
Historical cost	\$25,600
Less: adjusted accumulated depreciation	8,000
Adjusted historical cost	<u>\$17,600</u>
Basis for depreciation under the program:	
Declining balance method (Adjusted historical cost)	<u>\$17,600</u>
Straight-line and sum-of-the-years' digits methods:	
Adjusted historical cost	\$17,600
Less: estimated salvage value	1,600
Basis for depreciation	<u>\$16,000</u>

347. DEPRECIATION METHODS

Three methods are acceptable for computing depreciation, namely the straight line, sum-of-the-years' digits, and declining balance methods. However, the accelerated methods of depreciation—sum-of-the-years' digits and declining balance—may be used only if the asset's expected useful life under the program is more than 3 years. Regardless of the method of depreciation being used, an asset should not be depreciated below its salvage value. No additional first year 20% depreciation bonus is allowable.

A GPPP may elect any one of the three acceptable methods. A formal election procedure is unnecessary for depreciable assets held at the time of entrance in the program or for assets subsequently acquired. The depreciation method used in claiming depreciation on a particular asset for the first time will be presumed to be the depreciation method selected for that asset. A GPPP need not use the same method for all depreciable property, and a GPPP may elect to use a different depreciation method for similar property acquired later. However, if a GPPP wishes to change methods, a formal request and approval by the SSA will be necessary.

347.1 Straight-Line Method.—Under this method the annual allowance is determined by dividing the cost of the asset (less any estimated salvage value) by the years of useful life. This method produces a uniform allowance each year. The following examples illustrate how depreciation is computed:

NEW ASSET

<i>Facts:</i> Acquisition cost	\$17,000
Estimated salvage value	2,000
Estimated useful life	5 years

Annual depreciation is computed as follows:

Acquisition cost	\$17,000
Less: estimated salvage value	2,000
Basis for depreciation	<u>\$15,000</u>
Depreciation:	

$$\frac{\text{Basis for depreciation}}{\text{Useful Life}} = \frac{\$15,000}{5 \text{ years}} = \$3,000 \text{ each year}$$

The annual allowance can also be computed by using a percentage applied to the basis for depreciation. For example, in the above illustration, a five year life produces a 20% rate (100%/5 years). This 20% rate, when applied to the \$15,000 basis for depreciation results in an annual \$3,000 depreciation allowance for each of the five years.

USED ASSET

Facts: Historical cost	\$46,000
Salvage value	1,000
Estimated useful life	15 years
Years asset was used by GPPP before entry into Medicare program	10 years

Straight-line method of depreciation to be used for Medicare purposes. Annual depreciation is computed as follows:

a. Determine the number of remaining years of useful life (15 years minus 10 years = 5 years of remaining useful life).

b. Determine the basis for depreciation as follows:

Cost	\$46,000
Deduct: Salvage Value	1,000
Balance	\$45,000
Deduct: Accumulated depreciation under the straight-line method for 10 years	
(10 years x \$45,000)	\$30,000
15 years	
Basis for depreciation	\$15,000

c. Divide the basis for depreciation by the number of years of remaining life:

$$\frac{\text{Item b}}{\text{Item a}} = \frac{\$15,000}{5 \text{ years}} = \$3,000 \text{ annual depreciation}$$

347.2 Sum-of-the-Years' Digits Method.—Under this method, the annual depreciation allowance is computed by multiplying the basis for depreciation (cost less estimated salvage value) by a constantly decreasing fraction. The numerator of the fraction represents the remaining years of useful life of the asset at the beginning of each year and the denominator represents the sum of the years of estimated useful life at the time of acquisition in case of new assets or at the time of entrance into the program in the case of used assets. The following example illustrates how depreciation is computed.

NEW ASSET

Facts: Cost	\$17,000
Estimated salvage value	2,000
Estimated useful life	5 years

Depreciation is computed as follows:

a. Add each number in the estimated useful life (5 years: 1 + 2 + 3 + 4 + 5 = 15).

b. Use the sum 15 as the denominator of the fraction.

c. Each year, for the numerator of the fraction, use the remaining years of useful life including the year for which depreciation is taken.

This means using each number in a. above in inverse order (5, 4, 3, 2, 1,) i.e., 5 for the first year, 4 for the second year, 3 for the third year, etc.

d. Multiply the basis for depreciation by this fraction ($\frac{c}{b}$).

Cost	\$17,000
Salvage	2,000
Basis for depreciation =	\$15,000

ANNUAL COMPUTATION

Year	Basis for depreciation	Ratio	Annual Depreciation allowance
1st	\$15,000	x 5/15 =	\$5,000
2nd	15,000	x 4/15 =	4,000
3rd	15,000	x 3/15 =	3,000

USED ASSET

Facts: Cost	\$46,000
Salvage value	1,000
Estimated useful life	15 years
GPPP used asset (prior to entry into program)	10 years

Annual depreciation is computed as follows:

a. Determine the number of years of useful life remaining (15 minus 10 = 5 years of remaining useful life).

b. Add each number of the remaining years of useful life (5 years = 1 + 2 + 3 + 4 + 5 = 15).

c. Use the sum 15 as the denominator of the fraction.

d. Each year, for the numerator of the fraction, use the remaining years of useful life including the year in which depreciation is taken. This means using each number in b. above in inverse order (5, 4, 3, 2, 1), i.e., 5 for the first year under the program, 4 for the second year, 3 for the third year, etc.

e. Determine the basis for depreciation as follows:

Cost	\$46,000
Deduct: Salvage Value	1,000
Balance	\$45,000
Deduct: Accumulated depreciation under straight-line method for 10 years	
(\$45,000 x 10 years)	\$30,000
15 years	
Basis for depreciation	\$15,000

f. Multiply the basis for depreciation "e" by the fraction $\left(\frac{d}{c}\right)$ to determine annual depreciation.

ANNUAL COMPUTATION

Year	Basis	Ratio	Annual depreciation allowance
1st	\$15,000	x 5/15	= \$5,000
2nd	\$15,000	x 4/15	= 4,000
3rd	\$15,000	x 4/15	= 3,000

347.3 Declining Balance Method.—Under this method the annual allowance is computed by multiplying the undepreciated balance of the asset each year by a uniform rate up to double the straight-line rate. Salvage value is not considered in computing the depreciation allowance.

NEW ASSET

Facts: Cost	\$17,000
Estimated useful life	5 years
Salvage value	\$ 2,000
Rate to be used (double the straight-line rate: 2 x 20%)	= 40%

Annual depreciation is computed as follows:

Year	Undepreciated balance	Rate	Annual depreciation allowance
1st	\$17,000	x 40%	\$ 6,800
2nd	10,200	x 40%	4,080
3rd	6,120	x 40%	2,448

USED ASSET

Facts: Cost	\$46,000
Salvage value	1,000
Estimated useful life	15 years
GPPP used asset (prior to entry into program)	10 years

Double the straight-line rate to be used under the program. Annual depreciation is computed as follows:

a. Determine the number of remaining years of useful life (15 minus 10 = 5 years of remaining useful life)

b. Determine the straight-line rate for the remaining years of useful life (100% divided by 5 years = 20%)

c. Double the straight-line rate (2 × 20% = 40%)

d. Determine the basis for depreciation as follows:

Cost	\$46,000
Deduct: Salvage Value	1,000
Balance	\$45,000

Deduct: Accumulated depreciation under straight-line method for 10 years

	<u>10 yrs</u>	
\$45,000 x	15 yrs	\$30,000
Balance		<u>\$15,000</u>
Add: Salvage value		1,000

Basis for depreciation (or unrecovered cost in first year under the program) \$16,000

e. Multiply each year's undepreciated balance (or unrecovered cost) by 40% (Note: Do not depreciate the asset below its salvage value.)

Year	Undepreciated Balance	Rate	Annual Allowance Depreciation
1st	\$16,000	x 40%	\$6,400
2nd	\$ 9,600	x 40%	\$3,840
3rd	\$ 5,760	x 40%	\$2,304
4th	\$ 3,456	x 40%	\$1,382
5th	\$ 2,074	x 40%	\$ 830

347.4 Comparison of Depreciation Methods.—

A comparison of annual depreciation under each of the three acceptable methods of computing depreciation is reflected in the following table. (Salvage value at the end of the fifth year is \$2,000):

Straight-line	Sum-of-the-years' digits	Double Declining Balance
Rate: —20%	(5/15, 4/15, 3/15, etc.)	(40%)

Year	Undepreciated Balance	Annual Balance	Undepreciated Balance	Annual Allowance	Undepreciated Balance	Annual Allowance
	\$17,000		\$17,000		\$17,000	
	–2,000 (Salvage Value)		–2,000 (Salvage Value)		0 (No Salvage Value)	
1st	\$15,000	\$ 3,000	\$15,000	\$ 5,000	\$17,000	\$ 6,800
2nd	12,000	3,000	10,000	4,000	10,200	4,080
3rd	9,000	3,000	6,000	3,000	6,120	2,448
4th	6,000	3,000	3,000	2,000	3,672	1,469
5th	3,000	3,000	1,000	1,000	2,203	203*
		<u>\$15,000</u>		<u>\$15,000</u>		<u>\$15,000</u>

*Although depreciation at 40% of the undepreciated balance would amount to \$881, this amount cannot be used because an asset cannot be depreciated below its salvage value, and \$881 would bring the undepreciated balance below salvage value (\$2,000). Instead, however, the amount of depreciation to be taken for the fifth year would be the amount that would bring the undepreciated balance to the salvage value:

Undepreciated balance at beginning of 5th year	\$2,203
Salvage Value	2,000
Maximum depreciation for 5th year	<u>\$ 203</u>

348. DETERMINING DEPRECIATION IN YEAR OF ACQUISITION AND DISPOSAL

The amount of depreciation recorded during the year of acquisition and year of disposal may vary among plans. The following methods are acceptable for computing first and last year depreciation amounts. Any other method for computing first and last year depreciation must be approved by the SSA. Whatever method is adopted, it must be applied to all assets subsequently acquired.

1. *Time Lag Alternatives.*—These result in delayed recording of depreciation after the actual date of acquisition. However, they provide the convenience of updating detailed, supportive accounting records at the end of certain extended time intervals.

a. *Up to 6 Months Time Lag.* Assets acquired during the first 6 months of the reporting year are subject to depreciation beginning with the first day of the seventh month of the reporting year.

Assets acquired during the second 6 months of the reporting year are subject to depreciation beginning with the first day of the subsequent reporting year.

Depreciation on disposal is based on the portion of the year in which the asset is disposed of. If the asset is disposed of in the first half of the reporting year, one-half year's depreciation is taken. If the asset is disposed of in the second half of the year, a full year's depreciation is taken.

b. *Up to One Year Time Lag.* Assets acquired during the reporting year become effective for depreciation on the first day of the subsequent reporting year. In the year of disposal a full year's depreciation is taken.

Note: A variation of the above methods by use of a quarterly or monthly basis for determining depreciation in the first year and the year of disposal, would be acceptable.

2. *Half Year Depreciation.*—One half year's depreciation is taken in the year of acquisition regardless of acquisition date and one half year's depreciation is taken on disposition regardless of disposition date.

3. *Actual Time Depreciation.*—Depreciation for the first reporting period is based on the length of time from the date of acquisition to the end of the reporting year. Depreciation on disposal is based on the length of time from the beginning of the reporting year in which the asset was disposed of to the date of disposal.

349. CHANGE OF DEPRECIATION METHOD

Generally, a GPPP will adhere to the particular depreciation method or methods selected initially until final depreciation of the asset. After the initial selection, a GPPP may change only once to any of the other allowable methods, provided advance approval has been obtained from the SSA, Division of Reimbursement, BHI. A request for change in the depreciation method must be made no later than the last day of the first month of the accounting year in which the new method is to be employed.

If the new method of depreciation is the straight-line or sum-of-the-years' digits, the basis for depreciation will be the undepreciated balance (unrecovered cost) reduced by the salvage value. If the new method of depreciation is the declining balance the basis for depreciation will be the undepreciated balance (unrecovered cost).

The new basis for depreciation will be treated as though it were the basis for depreciation of a new asset, and depreciation would be based on the remaining years of useful life. (In this respect, see the computation of depreciation on "used" assets under the particular method of depreciation, § 350ff.)

350. CHANGING ESTIMATED USEFUL LIFE

350.1 Assets Acquired After GPPP's Entrance Into the Program.—When the estimate of the useful life of such an asset is changed, the undepreciated balance as of the date of change is depreciated over the new remaining useful life. The following examples illustrate how the new annual depreciation is computed under the *accelerated* methods of depreciation.

Example #1—Declining Balance Method

An asset costing \$10,000 and having an estimated useful life of 10 years has been depreciated for 6 years

at the declining balance rate of 20%. The depreciation accumulated during the 6 years is \$7,378.60, and the undepreciated balance is \$2,621.40.

At the end of the sixth year, it is determined that the remaining useful life is 8 years. Accordingly, future depreciation must be computed as though the estimate of useful life was originally determined to be 14 years. The applicable depreciation rate would be 14-2/7% (twice straight-line rate of 7-1/7%). This rate would be applied to the undepreciated balance. Thus, for the 7th year the depreciation would be 14-2/7% times \$2,621.40—or \$374.49.

Example #2—Sum-of-the-Years' Digits Method

An asset having estimated useful life of 10 years is purchased for \$10,500. Salvage value is estimated at \$500. After five years the accumulated depreciation under the sum-of-the-years' digits method amounts to \$7,272.70; the undepreciated balance of the cost is \$3,227.30. At the beginning of the sixth year it is determined that the asset has 9 years more of useful life.

Depreciation for the sixth year should be computed as though the sixth year were the first year of life on an asset estimated to have a useful life of 9 years. Accordingly, the depreciation for the sixth year (or first year under the new estimate) would be computed as follows:

Basis for depreciation	
Unrecovered cost	\$3,227.30
Less: Salvage value	500.00
Basis for depreciation	<u>\$2,727.30</u>
Sum-of-the-years' digit (1+2+3, etc --9)	45
Depreciation = 9/45 x \$2,727.30 =	<u>\$ 545.46</u>

350.2 Assets Acquired Before GPPP's Entrance into the Program.—Where a change is made in the estimate of the useful life of an asset that was acquired before the GPPP's entrance into the program, it will be necessary to correct prior years' depreciation for both the periods before and after entrance into the program. The following example illustrates how the correction is computed.

Facts:

Asset acquired 3 years before entrance into program	
Historical cost of the asset	\$30,500
Estimated remaining useful life at entrance into program	7 years
Estimated salvage value	\$ 500

Straight-line depreciation used under the program.

At the beginning of the 5th year under the program it is estimated that the asset has 8 more years of useful life.

Computation of depreciation for the 5th year under the program

New estimated useful life	15 years
3 years before the program	
4 years under the program	
8 more years useful life	
15 years of useful life	
Historical cost	\$30,500
Depreciation accumulated prior to program (\$30,500-\$500(salvage value))	
(3 years x 15 years)	6,000
Adjusted historical cost	<u>\$24,500</u>
Deduct: Salvage value	500
Adjusted basis for depreciation under the program	<u>\$24,000</u>
Annual depreciation under the program (\$24,000)	
12 years of useful life under program	<u>\$ 2,000</u>
Depreciation for the fourth year and annually thereafter is	<u>\$ 2,000</u>

350.3 Correction of Prior Years' Depreciation.

Original estimated useful life	10 years
Historical cost	\$30,500
Depreciation accumulated prior to program on basis for estimate of 10 years' useful life	
(\$30,500-\$500)	
(3 years x 10 years)	9,000
Adjusted historical cost	<u>\$21,500</u>
Deduct: Salvage value	500
Adjusted basis for depreciation under the program	<u>\$21,000</u>
Depreciation that was taken under the program in four years	\$21,000
(4 years x 7 years)	\$12,000
Corrected depreciation for four years under the program based on estimated useful life of 15 years (4 years x \$2,000 final depreciation)	<u>8,000</u>
Reduction of prior years' depreciation under the program	<u>\$4,000*</u>

*Reduction of \$4,000 must be applied to current year's depreciation.

351. OPTIONAL ALLOWANCE FOR DEPRECIATION BASED ON A PERCENTAGE OF OPERATING COSTS

For all depreciable assets acquired before January 1, 1966, the GPPP at its option may at the time it enters the program choose an allowance for depreciation based on a percentage of operating costs. This option is available to any plan, regardless of whether or not

the plan has historical cost records of these assets. However, a plan that has elected to use actual depreciation cannot at a later date switch to the optional allowance.

The operating costs to be used are the lower of the plan's 1965 operating costs or the plan's current year's allowable costs. The percentage to be applied is 5 percent for all reporting periods beginning in the year 1966-67 (July 1, 1966-June 30, 1967); 4½ percent for all reporting periods beginning in the year 1967-68 (July 1, 1967-June 30, 1968), with such percentage being uniformly reduced by one-half percent each succeeding year.

The allowance based on operating costs is in addition to regular depreciation on assets acquired after 1965. However, when the optional allowance is selected, the combined amount of such allowance on pre-1966 assets and the straight-line depreciation on assets acquired after 1965, and the estimated depreciation on a straight-line basis on all rented assets used during the current year may not exceed 6 percent of the provider's adjusted allowable cost for the current year. In applying this limitation if the actual depreciation claimed on post-1965 assets is on an accelerated basis, it must be converted to a straight-line basis only for use in computing this limitation. The actual depreciation claimed on an accelerated basis is properly includable in allowable costs.

351.1 Operating costs are the total costs, related to medical services incurred by the plan in operating the facility.

1965 operating costs are the plan's operating costs incurred in the plan's fiscal year beginning in the period August 1, 1964, through July 31, 1965, without adjustment to Medicare's principles of reimbursement for provider costs. When the 1965 operating costs are used as a base for determining the optional allowance for depreciation, such costs must be adjusted to exclude the estimated depreciation on rented depreciable type assets or the rental charge for such assets, whichever is lower; and in addition, the 1965 operating cost must not include any actual depreciation, an amount in lieu of specific recognition of other costs.

351.2 Allowable costs are those includable in cost reimbursement under the guidelines for reimbursement of GPPP's. When the current year's allowable costs are used as a base for the optional allowance for depreciation, they should be adjusted to exclude (1) any actual depreciation, (2) the lesser of rental charges or estimated depreciation on rented depreciable type assets, and (3) allowance in lieu of specific recognition of their costs. The exclusion of these three items is only for the purpose of computing the optional allowance for depreciation. For other purposes, rental charges and excluded items (1) and (3) are recognized in determining allowable costs and for computing the

costs of services rendered to the program beneficiaries during the reporting period.

Where a provider files a short-period report, the allowable costs must be converted to a full year's basis (see example 3 in § 351.3 below) only for the purpose of computing the optional allowance.

351.3 Applicable Percentages—The percentage to be applied in each reporting year is shown in the following schedule:

<i>Reporting year beginning</i>			<i>Percentage Allowance</i>
<i>After</i>	<i>but</i>	<i>Before</i>	
—		7/1/67	5
6/30/67		7/1/68	4½
6/30/68		7/1/69	4
6/30/69		7/1/70	3½
6/30/70		7/1/71	3
6/30/71		7/1/72	2½
6/30/72		7/1/73	2
6/30/73		7/1/74	1½
6/30/74		7/1/75	1
6/30/75		7/1/76	½
6/30/76		7/1/77	0

Computation of optional allowance for depreciation

The following illustrates the determination of the optional allowance for depreciation based on operating costs:

Example 1
Facts

The plan keeps its records on a calendar year basis. The current year's actual allowable cost and the actual operating costs for 1965 do not include any actual depreciation or rentals on depreciable type assets. The current years' allowable cost has been adjusted to remove any allowance in lieu of specific recognition of other costs.

Computation

First Reporting Period (January 1, 1966—December 31, 1966)

Adjusted current year's allowable cost	\$1,100,000
Operating cost for 1965 ¹	\$1,000,000
Percent for determining the allowance	5%
Allowance (5% x \$1,000,000)	\$ 50,000

¹ 1965 operating cost was used in computing the allowance for depreciation because it was lower than 1966 adjusted allowable cost.

Second Reporting Period (January 1, 1967—December 31, 1967)

Adjusted current year's allowable cost	\$1,200,000
Operating cost for 1965 ¹	\$1,000,000
Percent for determining the allowance ²	5%
Allowance (5% x \$1,000,000)	\$ 50,000

¹ 1965 operating cost was used in computing the allowance for depreciation because it was lower than 1967 adjusted allowable cost.

² Since the reporting period began during the year 1966-67 (July 1, 1966—June 30, 1967) 5 percent is the percentage to be used.

Third Reporting Period (January 1, 1968—December 31, 1968)

Operating cost for 1965	\$1,000,000
Current year's adjusted allowable cost ¹	\$ 900,000
Percent for determining the allowance ²	4½%
Allowance (4½% x \$900,000)	<u>\$ 40,500</u>

¹ The current year's adjusted allowable cost was used in computing the allowance for depreciation because it was lower than 1965 operating cost.

² Since the reporting period began during the year 1967-68 (July 1, 1967,—June 30, 1968) 4½% percent is the percentage to be used.

Example 2

Facts

The plan keeps its records on a *calendar year basis*. The current year's actual allowable cost and the actual operating cost for 1965 did not include any actual depreciation. However, both 1965 and the current year's costs have been adjusted to exclude depreciation (\$3,000 for 1965, \$2,000 the current year) on rented depreciable type assets. The current year's allowable cost has also been adjusted to remove the allowance in lieu of specific recognition of other costs.

Computation

First Reporting (January 1, 1966—December 31, 1966)

Adjusted current year's allowable cost	\$1,100,000
Adjusted operating cost for 1965 ¹	\$1,000,000
Percent for determining the allowance	5%
Allowance (5% x \$1,000,000)	\$ 50,000
Less: Estimated depreciation for depreciable type assets rented prior to 1966 on which rental of \$5,000 is paid in 1966	\$ 3,000
Adjusted allowance	<u>\$ 47,000</u>

¹ 1965 adjusted operating cost was used in computing the allowance for depreciation because it was lower than 1966 adjusted allowable cost.

Example 3

Facts

The plan keeps its records on a *calendar year basis*. The provider's first report will be a short period one of six months, July 1, 1966—December 31, 1966. The current year's actual allowable cost and the operating costs for 1965 do not include any actual depreciation or rentals on depreciable type assets. The current

year's allowable cost has been adjusted to remove the allowance in lieu of specific recognition of other costs.

Computation

First Reporting Period (July 1, 1966—December 31, 1966)

Adjusted current year's allowable cost (six months)	\$ 575,000
Adjusted current year's allowable cost converted to a 12 month period (2 x \$575,000)	\$1,150,000
Operating cost for 1965 ¹	\$1,000,000
Percent for determining allowance	5%
Allowance (5% x \$1,000,000)	<u>\$ 50,000</u>

¹ 1965 operating cost was used in computing the allowance for depreciation because it was lower than the adjusted allowable costs covering a 12 month period.

Second Reporting Period (January 1, 1967—December 31, 1967)

Adjusted current year's allowable cost	\$1,200,000
Adjusted operating cost for 1965 ¹	\$1,000,000
Percent for determining the allowance	5%
Allowance (5% x \$1,000,000)	\$ 50,000
Less: Estimated depreciation for depreciable type assets rented prior to 1966 on which a rental of \$5,000 is paid in 1967	\$ 3,000
Adjusted allowance	<u>\$ 47,000</u>

¹ 1965 operating cost was used in computing the allowance for depreciation because it was lower than the 1967 adjusted allowable costs.

351.4 Limitation.—The optional allowance only—not the actual depreciation—is subject to a limitation based on the provider's total allowable operating cost for the current year. To determine this limitation, compute the sum of (1) the actual depreciation claimed for post-1965 assets computed on a straight-line basis, (2) "the optional allowance based on a percentage of operating costs," and (3) the estimated depreciation on depreciable type rented assets used in the current year. If this sum exceeds six percent of the provider's current year's adjusted allowable cost (allowable cost reduced by any depreciation claimed, the estimated depreciation on rented depreciable type assets, and allowance in lieu of specific recognition of other costs), the optional allowance for depreciation must be reduced by the amount of the excess. In applying this limitation if the actual depreciation is on an accelerated basis, it must be converted to a straight-line basis only for use in calculating this limitation.

Where a GPPP files a short-period report, the period's allowable costs, after adjustment to exclude the 4 items mentioned above, must be converted to a full

year's basis (see example 3 in § 351.3). Thus, if the short period is for 8 months, the adjusted allowable costs should be increased by 50%; if the short period is for 9 months, the adjusted allowable cost should be increased by 33 $\frac{1}{3}$ %, etc. In addition, the actual depreciation computed on a straight-line basis as well as the estimated depreciation on rented depreciable type assets must be converted to a 12 month or full year's basis.

The following illustration demonstrates how the limitation is determined:

Example 4

Facts

The plan keeps its records on a calendar year basis. For its first report, the plan will use a six month's period. The current year's actual allowable cost and the actual operating cost for 1965 have been adjusted to exclude actual depreciation, the estimated depreciation on rented depreciable type assets, and allowance in lieu of specific recognition of other costs.

Adjusted operating cost for 1965	\$1,000,000
Adjusted allowable operating cost for the last six months of 1966	\$ 550,000
In 1966, assets were acquired which produced for 1966 a straight-line depreciation of	\$ 18,000
Estimated depreciation for the year on rented assets used in 1966	\$ 4,000
Estimated annual depreciation on assets rented prior to 1966 for which an annual rental of \$5,000 is paid	\$ 3,000

Computation of the Optional Allowance

First Reporting Period (July 1, 1966—December 31, 1966)

Adjusted allowable costs for the last 6 months of 1966 converted to a 12 month basis (2 x \$550,000)	\$1,100,000
Gross optional allowance: 5% of adjusted 1965 operating cost (\$1,000,000) ¹	\$ 50,000
Less: Estimated depreciation on assets rented prior to 1966	\$ 3,000
Gross allowance	\$ 47,000
Add: Estimated depreciation for the year on rented assets used in 1966	\$ 4,000
Straight-line depreciation of post-1965 assets for 12 months	18,000
Total	\$ 69,000
6% of adjusted 1966 allowable operating cost (6% x 1,100,000)	\$ 66,000
Deduction in allowance	\$ 3,000
Gross allowance	\$ 47,000
Less: Reduction for excess of 6% limitation	\$ 3,000

Net optional allowance for the year	\$ 44,000
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Net optional allowance converted to a 6 month period (\$44,000 ÷ 2)	\$ 22,000
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¹ The adjusted 1965 operating cost is used because it is lower than the adjusted allowable cost converted to a 12-months period.

Second Reporting Period (January 1, 1967—December 31, 1967)

Facts

Adjusted allowable cost for 1967	\$1,150,000
Adjusted operating cost for 1965	1,000,000
Percent for determining the allowance	5%
Straight-line depreciation on assets acquired after 1965	\$ 20,000
Estimated depreciation on \$7,000 rental of depreciable type assets used in 1967	4,000
Estimated depreciation on depreciable assets rented prior to 1966 on which annual rental of \$5,000 is paid	3,000

Computation

Gross Optional Allowance

5% times adjusted 1965 operating cost (5% x \$1,000,000)	\$ 50,000
Less: Estimated depreciation on depreciable assets rented prior to 1966	3,000
Adjusted allowance	\$ 47,000
Add: Straight-line depreciation on post-1965 assets	20,000
Estimated depreciation on depreciable rented assets used in 1967	4,000
Total	\$ 71,000
Less: 6% of adjusted 1967 allowable operating cost	\$ 69,000
Deduction to adjusted allowance	\$ 2,000

Net allowance to be included in allowable costs:

Adjusted allowance	\$ 47,000
Less: Deduction to adjusted allowance	2,000
Net allowance	\$ 45,000

352. CHANGE FROM OPTIONAL ALLOWANCE TO ACTUAL DEPRECIATION

A GPPP that elects the optional allowance for depreciation may at any time before 1976 change to actual depreciation on its pre-1966 assets. When a plan switches to actual depreciation it can no longer elect the optional allowance.

When a GPPP changes to actual depreciation, the depreciation accumulated to the date of change will be determined in the same manner as accumulated depreciation is determined for used assets when a plan enters the program. Upon disposition of the asset, the

determination of gain or loss will be made on the basis of historical cost depreciation for the actual useful life of the asset.

353. ESTIMATED DEPRECIATION PENDING APPRAISAL

A. Rule.—For those GPPP's not wishing to use the optional method of depreciation and who have signed contracts to have appraisals made to establish the costs of pre-1966 assets, a reasonable estimate of the actual depreciation may be made, pending completion of the appraisal. Such appraisal must be completed within two years of the contract date. Until the appraisal is completed, an estimated depreciation may be taken for the current cost report with a retroactive adjustment to the estimated depreciation to be made when the appraisal is completed.

B. Limitation.—The estimated depreciation may not exceed 5 percent of 1965 operating costs or the current year's allowable costs, as adjusted for computing the optional allowance for depreciation, whichever is lower. The total allowable estimated depreciation is also subject to an adjustment based on the GPPP's adjusted allowable cost for the current year. To determine this limitation, compute the sum of (1) the actual depreciation claimed for post-1965 assets determined on a straight-line basis, (2) estimated depreciation on rented depreciable type assets used in the current year, and (3) the estimated depreciation on pre-1966 assets. If this sum exceeds 6 percent of the GPPP's adjusted current year's allowable cost (allowable cost exclusive of any depreciation claimed, estimated depreciation on rented depreciable type assets, and allowance in lieu of specific recognition of other costs), the reasonable estimated depreciation must be reduced by the amount of the excess.

When the appraisal has been completed, actual depreciation must be computed for the year(s) in which estimated depreciation was taken and compared with the amount of depreciation claimed on the cost report(s). The GPPP may either submit amended cost report(s) for the year(s) in question or it may adjust the current year's depreciation to reflect the difference between the estimated depreciation and depreciation based on the appraisal of the asset's historical cost. Any current year adjustment must reflect the Medicare percentages of participation for the year(s) in question applied to the difference between the estimated depreciation and depreciation based on the appraisal.

354. DISPOSAL OF ASSETS

Depreciable assets may be disposed of through sale, trade-in, scrapping, exchange, theft, wrecking, fire, or other casualty. In such cases, depreciation can no longer be taken on the asset, and gain or loss on the disposition must be computed.

Where an asset has been retired from active service, but is being held for stand-by or emergency services, depreciation may continue to be taken on it. However, where the asset has been permanently retired or there is little or no likelihood that it can be effectively used in the future, no further depreciation can be taken on the asset. In such case, gain or loss on the retirement must be computed.

354.1 Gains and Losses on Disposal of Depreciable Assets.—Gains and losses on the disposition of depreciable assets are includable in computing allowable costs. However, gain on the disposal of an asset must not exceed the depreciation accumulated for that asset under the program.

If the gains or losses on the disposal of depreciable assets in a reporting period are greater than 10% of the total allowable depreciation for the period, the amount of the excess gain or loss over the 10% must be carried forward over the five succeeding years. The identification of the gain or loss carry-forward for each individual year must be maintained in the records. The carry-forwards must be considered first in determining the ten percent limitation for the current year.

354.2 Computation of Gain or Loss.—When an asset that was acquired before entrance into the program is disposed of, a correction of prior years' depreciation based on *actual* useful life must be made before determining any gain or loss. The actual useful life will cover the period from date of acquisition to date of disposal. The depreciation accumulated before and after entrance into the program must be corrected in the same manner as when making a new estimate of the asset's useful life. (See § 350 on "Changing Estimated Useful Life".) The gain or loss is the difference between the amount received for the disposed asset and the corrected undepreciated cost at the time of sale. However, where an asset is traded-in for another asset there will be neither a gain nor loss on the disposition. (See § 338, "Depreciation-Historical Cost," for determining cost of new asset when a trade-in is involved.)

The following example illustrates how to compute gain or loss on disposal of an asset that was acquired before entrance into the program:

Facts

Asset acquired 10 years before entrance into the program	10 years
Estimated remaining useful life at entrance into program	20 years
Total useful life	30 years
Estimated salvage value	\$ 10,000
Historical cost	\$310,000
Salvage value	10,000

Sum-of-the-years' digits method of depreciation used under the program	\$300,000
Accumulated depreciation before entrance into program (using straight-line depreciation)	\$100,000
Undepreciated balance subject to depreciation under the program	\$200,000
Asset sold at the end of the 15th year under the program for	\$ 1,000
Depreciation accumulated under program for 15 years	\$185,714

Computation of Gain or Loss

Historical cost	\$310,000
Corrected accumulated depreciation upon entering program—\$300,000 10 years x 25 years	\$120,000
Undepreciated balance subject to depreciation under the program	\$190,000
Less: Estimated salvage value	10,000
Basis for depreciation—also, total depreciation allowable under the program	\$180,000
Historical cost	\$310,000
Accumulated depreciation before and after entrance into program (\$120,000 + \$180,000)	\$300,000
Unrecovered cost	\$ 10,000
Sales price	1,000
Loss	\$ 9,000
Share of loss under program = 15 years (Medicare) 25 years (useful life) = x \$9,000 =	\$ 5,400
Share of loss under program	\$ 5,400
Correction of accumulated depreciation under the program:	
Depreciation taken	\$185,714
Correct depreciation	180,000
Excess depreciation taken	\$ 5,714
Reduction of depreciation for the year	\$ 314

354.3 Computation of Gain or Loss on Assets Acquired Under the Program.—Gain or loss on the disposal of assets acquired under the program is the difference between the sale price of the asset and the asset's unrecovered costs.

Example

Facts

Asset acquired for	\$310,000
Estimated life	30 years
Estimated salvage value	\$ 10,000
Asset sold at end of 25th year for	\$ 25,000
Sum-of-the-years' digits used in depreciating asset—	\$290,325

Computation of Gain or Loss

Sales price of assets	\$ 25,000
Less: Unrecovered cost:	
Historical cost	\$310,000
Deduct: Accumulated depreciation for 25 years	290,325
Gain on disposal	\$ 5,325

355. FUNDING OF DEPRECIATION COST ALLOWANCES

Funding of amounts reimbursed for depreciation costs is not required but such funding is strongly recommended. As an incentive, investment income earned from funded depreciation will not be applied as an offset against allowable interest costs.

356. ALLOWANCE FOR DEPRECIATION ON ASSETS FINANCED WITH FEDERAL OR PUBLIC FUNDS

Depreciation is allowed on assets financed with Hill-Burton or other Federal or public funds.

Like other assets (including other donated depreciable assets), assets financed with Hill-Burton or other Federal or public funds become a part of the plan's plant and equipment to be used in rendering services. It is the function of payment of depreciation to provide funds which make it possible to maintain the assets and preserve the capital employed in the production of services. Therefore, irrespective of the source of financing of an asset, if it is used in the providing of services for beneficiaries of the program, payment for depreciation of the asset is, in fact, a cost of the production of those services. Moreover, recognition of this cost is necessary to maintain productive capacity for the future. An incentive for funding of depreciation is provided in these principles by the provision that investment income on funded depreciation is not treated as a reduction of allowable interest expense under § 358.

358. INTEREST EXPENSE

Necessary and proper interest on both current and capital indebtedness is an allowable cost.

Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. This is usually for such purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as acquisition of facilities and equipment, and capital improvements. Generally, loans for capital purposes are long term loans.

"Necessary" requires that the interest:

a. Be incurred on a loan made to satisfy a financial need of the plan. Loans which result in excess

funds or investments would not be considered necessary.

b. Be incurred on a loan made for a purpose reasonably related to providing medical service.

c. Be reduced by investments income except where such income is from gifts and grants, whether restricted or unrestricted, and which are held separate and not commingled with other funds. Income from funded depreciation or plan's qualified pension fund is not used to reduce interest expense.

"Proper" requires that interest:

a. Be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made.

b. Be paid to a lender not related through control or ownership, or personal relationship to the borrowing organization. However, interest is allowable if paid on loans from the plan's donor-restricted funds, the funded depreciation account or the plan's qualified pension fund.

To be allowable, interest expense must be incurred on indebtedness established with lenders or lending organizations not related through control, ownership, or personal relationship to the borrower. Presence of any of these factors could affect the "bargaining" process that usually accompanies the making of a loan, and could thus be suggestive of an agreement on higher rates of interest or of unnecessary loans. Loans should be made under terms and conditions that a prudent borrower would make in arms-length transactions with lending institutions. The intent of this provision is to assure that loans are legitimate and needed, and that the interest rate is reasonable. Thus, interest paid by the plan to partners, stockholders, or related organizations of the plan would not be allowable. Where the owner uses his own funds in a business, it is reasonable to treat the funds as invested funds or capital, rather than borrowed funds.

Exceptions to the general rule regarding interest on loans from controlled sources of funds are made in the following circumstances. Interest on loans to plans by partners, stockholders, or related organizations made prior to July 1, 1966, is allowable as cost provided that the terms and conditions of payment of such loans have been maintained in effect without modification subsequent to July 1, 1966. Where the general fund of a plan "borrows" from a donor-restricted fund and pays interest to the restricted fund, this interest expense is an allowable cost. The same treatment is accorded interest paid by the general fund on money "borrowed" from the funded depreciation account of the plan or from the plan's qualified pension fund.

Where funded depreciation is used for purposes other than improvement, replacement, or expansion of facilities or equipment related to providing medical services, allowable interest expense is reduced to adjust

for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the plan's qualified pension fund where such deposits are used for other than the purpose for which the fund was established.

Allowable interest expense on current indebtedness of a plan will be adjusted to reflect the extent to which working capital needs, which are attributable to covered services for beneficiaries, have been met by payments to the plan designed to reimburse on a current basis as services are furnished to beneficiaries.

359. RESEARCH COSTS

Costs, incurred for research purposes, over and above usual patient care, are not includable as allowable costs.

There are numerous sources of financing for health-related research activities. Funds for this purpose are provided under many Federal programs and by other tax-supported agencies. Also, many foundations, voluntary health agencies and other private organizations, as well as individuals, sponsor or contribute to the support of medical and related research. Funds available from such sources are generally ample to meet basic medical and hospital research needs.

A further consideration is that quality review should be assured as a condition of governmental support for research. Provisions for such review would introduce special difficulties in the health insurance program.

Where research is conducted in conjunction with and as a part of the care of patients, the costs of usual patient care are allowable to the extent that such costs are not met by funds provided for the research.

Under this principle, however, studies, analyses, surveys, and related activities to serve the plan's administrative and program needs, are not excluded as allowable costs in the determination of reimbursement under Medicare.

360. GRANTS, GIFTS, AND INCOME FROM ENDOWMENTS

Unrestricted grants, gifts, and income from endowments should not be deducted from operating costs in computing reimbursable cost. Grants, gifts, or endowment income designated by a donor for paying specific operating costs should be deducted from the particular operating cost or group of costs.

Unrestricted grants, gifts, and income from endowments are funds, cash or otherwise, given to a plan without restriction by the donor as to use.

Designated or restricted grants, gifts, and income from endowments are funds, cash or otherwise, which must be used only for the specific purpose designated by the donor. This does not refer to unrestricted grants, gifts, or income from endowments which have been restricted for a specific purpose by the plan.

Unrestricted funds, cash or otherwise, are generally the property of the plan to be used in any manner its management deems appropriate and should not be deducted from operating costs. It would be inequitable to require plans to use the unrestricted funds to reduce the payments for care. The use of these funds is generally a means of recovering costs which are not otherwise recoverable.

Donor-restricted funds which are designated for paying certain operating expenses should apply and serve to reduce these costs or group of costs and benefit all patients who use services covered by the donation. If such costs are not reduced, the plan would secure reimbursement for the same expense twice: it would be reimbursed through the donor-restricted contributions as well as from patients and third-party payers including the health insurance program.

361. VALUE OF SERVICES OF NON-PAID WORKERS

The value of services in positions customarily held by full-time employees performed on a regular scheduled basis by individuals as non-paid members of organizations under arrangements between such organizations and a plan for the performance of such services without direct remuneration from the plan to such individuals is allowable as an operating expense for the determination of allowable cost subject to the limitation contained in the following paragraph. The amounts allowed are not to exceed those paid others for similar work. Such amounts must be identifiable in the records of the institutions as a legal obligation for operating expenses.

The services must be performed on a regular, scheduled basis in positions customarily held by full-time employees and necessary to enable the plan to carry out the functions of normal patient care and operation of the organization. The value of services of a type for which plans generally do not remunerate individuals performing such services is not allowable as a reimbursable cost under Medicare. For example, donated services of individuals in distributing books and magazines to patients, or in serving in a provider canteen or cafeteria or in a provider gift shop, would not be reimbursable.

362. PURCHASE DISCOUNTS AND ALLOWANCES, AND REFUNDS OF EXPENSES

Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense.

Discounts, in general, are reductions granted for the settlement of debts.

Allowances are deductions granted for damage,

delay, shortage, imperfection or other cause, excluding discounts and returns.

Refunds are amounts paid back or a credit allowed on account of an overcollection.

All discounts, allowances, and refunds of expenses are reductions in the cost of goods or services purchased and are not income. When they are received in the same accounting period in which the purchases were made or expenses were incurred, they will reduce the purchases or expenses of that period. However, when they are received in a later accounting period, they will reduce the comparable purchases or expenses in the period in which they are received.

Purchase discounts have been classified as cash, trade, or quantity discounts. Cash discounts are reductions granted for the settlement of debts before they are due. Trade discounts are reductions from list prices granted to a class of customers before consideration of credit terms. Quantity discounts are reductions from list prices granted because of the size of individual or aggregate purchase transactions. Whatever the classification of purchase discounts, like treatment in reducing allowable cost is required.

In the past, purchase discounts were considered as financial management income. However, modern accounting theory holds that income is not derived from a purchase but rather from a sale or an exchange and that purchase discounts are reductions in the cost of whatever was purchased. The true cost of the goods or services is the net amount actually paid for them. Treating purchase discounts as income would result in an overstatement of costs to the extent of the discount.

As with discounts, allowances and rebates received from purchases of goods or services and refunds of previous expense payments are clearly reductions in costs and must be reflected in the determination of allowable costs. This treatment is equitable and is in accord with that generally followed by other governmental programs and third-party payment organizations paying on the basis of cost.

362.1 Taxes.—When a plan is liable for the payment of certain taxes, such payments made in accordance with the levying enactment of the several states and lower levels of government may be included in allowable costs. The program will pay its proportionate share of such allowable expenses.

Plans are expected to obtain exemption from taxation whenever they can legally do so. When such exemptions are available but the plan neglects to take advantage of them, incurred expenses for such taxes will not be recognized as allowable costs under the program.

Tax expense should not include fines and penalties. In general, taxes which the plan is required to pay are includable in allowable costs except for:

1. Federal income and excess profit taxes.
 2. State or local income and excess profit taxes.
 3. Taxes in connection with financing, refinancing, or refunding operations, such as taxes on the issuance of bonds, property transfers, issuance or transfer of stocks, etc. Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are not, however, recognized as tax expense.
 4. Taxes from which exemptions are available to the plan.
 5. Special assessments on land which represent capital improvements such as sewers, water, and pavements should be capitalized and depreciated over their estimated useful life.
 6. Taxes on any property which is not used in the rendition of covered services.
 7. Sales taxes levied against the plan member and collected by the plan.
- Taxes which are allowable for inclusion in cost under the program generally are included in general and administrative expenses of the plan.

363. COMPENSATION OF OWNERS

A reasonable allowance of compensation for services of owners is an allowable cost, provided the services are actually performed in a necessary function.

Compensation means the total benefit received by the owner for the services he renders to the institution. It includes:

- a. Salary amounts paid for managerial, administrative, professional, and other services.
- b. Amounts paid by the institution for the personal benefit of the proprietor.
- c. The cost of assets and services which the proprietor receives from the institution.
- d. Deferred compensation.

Reasonableness requires that the compensation allowance:

- a. Be such an amount as would ordinarily be paid for comparable services by comparable institutions.
- b. Depend upon the facts and circumstances of each case.

Necessary requires that the function:

- a. Be such that had the owner not rendered the services, the institution would have had to employ another person to perform the services.
- b. Be pertinent to the operation and sound conduct of the institution.

Owners of organizations often render services as managers, administrators, or in other capacities. In

such cases, it is equitable that reasonable compensation for the services rendered be an allowable cost. To do otherwise would disadvantage such owners in comparison with corporate plans or plans employing persons to perform similar services.

Ordinarily, compensation paid to proprietors is a distribution of profits. However, where a proprietor renders necessary services for the institution, the institution is in effect employing his services, and a reasonable compensation for these services is an allowable cost. In corporate plans, the salaries of owners who are also employees are subject to the same requirements of reasonableness. Where the services are rendered on less than a full-time basis, the allowable compensation should reflect an amount proportionate to a full-time basis. Reasonableness of compensation may be determined by reference to, or in comparison with, compensation paid for comparable services and responsibilities in comparable institutions, or it may be determined by other appropriate means.

364. COST TO RELATED ORGANIZATIONS

Costs applicable to services, facilities, and supplies furnished to the plan by organizations related to the plan by common ownership or control are includable in the allowable cost of the plan at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

Related to the plan means that the plan to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

Common ownership exists when an individual (or individuals) possesses significant ownership or equity in the plan and the institution or organization serving the plan.

Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

Individuals and organizations associate with others for various reasons and by various means. Some deem it appropriate to do so to assure a steady flow of supplies or services, to reduce competition, to gain a tax advantage, to extend influence, etc. These goals may be accomplished in various ways such as by means of ownership or control, by financial assistance, or by management assistance.

Where the plan obtains items or services, facilities, or supplies from an organization, even though it is a separate legal entity, and the organization is owned or controlled by the owner(s) of the plan, in effect the items are obtained from itself. An example would be a

corporation building a hospital or a nursing home and then leasing it to another corporation controlled by the owner.

Therefore, reimbursable cost should include the costs for these items at the cost to the supplying organization. However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplier, the allowable cost to the plan shall not exceed the market price.

An exception is provided to this general principle if the plan demonstrates by convincing evidence to the satisfaction of the SSA that the supplying organization is a bona fide separate organization; that a substantial part of its business activity of the type carried on with the plan is transacted with others than the plan and organizations related to the supplier by common ownership or control and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those which commonly are obtained by organizations such as the plan from other organizations and are not a basic element of medical care ordinarily furnished directly to patients by such institutions; and that the charge to the plan is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies. In such cases, the charge by the supplier to the plan for such services, facilities, or supplies shall be allowable as cost.

365. ALLOWANCE IN LIEU OF SPECIFIC RECOGNITION OF OTHER COSTS

In lieu of specific recognition of other costs in providing and improving services, an allowance amounting to 2 percent of allowable costs (with the exception of interest expense and the allowance under this principle) is includable as an element of reasonable cost of services.

Difficulty in measurement, lack of adequate data and other considerations have precluded specific recognition of various elements which are germane to costs of services for beneficiaries. Moreover, although the methods to be utilized by plans for determining the actual cost of services provided to beneficiaries are the best available, there is some lack of precision in methods for determining costs at the present stage of development of cost finding which represents a contingency for which recognition is appropriate. It is the established practice of a significant number of large third-party purchasers to include in payment for costs of services a factor in the form of an allowance to cover various elements not specifically recognised or not precisely measured.

Program Costs

370. COSTS RELATED TO PARTICIPATION IN THE PROGRAM (SECTION 1874 COSTS)

A. *General.*—GPPP's reimbursed directly by the Social Security Administration are required to perform certain extra and identifiable functions which are not part of their normal operating functions. If the cost of these functions were considered care costs, the plans would recover less than 80% of the actual costs and a portion of the costs would be passed on to their subscribers through premiums. Therefore, the Administration agreed to pay 100% of the costs incurred in performing those extra and identifiable functions required by SSA which are not related to furnishing care. Any costs incurred under this section must be kept separate from those related to furnishing medical services and will be reimbursed separately to the plans. Care must be exercised to assure that reimbursement for these costs is not duplicated in the reimbursement of care costs.

Funds for these special costs are included in the Social Security Administration's annual budget. To obtain the necessary data for the SSA budget, each of the plans must submit an estimate of the special costs to be incurred, by function, in the performance of the assigned special tasks.

B. *Reimbursable Functions.*—The agreement between the plans and the SSA sets forth a general description of the types of functions that the Secretary may request the plans to undertake. These are:

1. Establish a system to complete reports for statistical studies requested by the SSA including, but not limited to, 100 percent reporting of specified services;

2. Upon written request of the Secretary, furnish actuarial data to develop utilization, time, and other factors generally entering into the reimbursement of the plans;

3. Obtain health insurance claim members from beneficiaries and transmit data, initially and on a continuing basis, as required to annotate the SSA master file;

4. Establish and carry out such controls over utilization as may be mutually agreed upon by the plan and the Secretary;

5. Perform such other functions as result from the special requirements of the Act and the SSA. Specific categories of expenses will be subject to review and prior approval by the Secretary, in accordance with the Principles of Reimbursement for Prepayment Costs issued by the Secretary; and

6. Furnish special reports and perform such other duties as may be mutually agreed upon.

Items 1 and 3 above are currently assigned to all

plans. Except for these items, plans must obtain an advanced understanding before undertaking any function for which reimbursement of costs will be claimed.

C. *Advanced Understanding.*—In order to avoid possible subsequent disallowance, based on unreasonable costs or nonallocability, it is important that the plans have a written understanding with SSA in advance of undertaking any function for which reimbursement of costs will be claimed.

Plans should provide SSA with a detailed description of what, how, and why the function to be undertaken is necessary to the contract.

D. *Allowable Costs.*—Costs incurred by a plan which can be attributed to functions assigned in accordance with the agreement will be considered necessary and proper cost for purposes of payment.

To be allowable, costs allocated to the Federal Government under the agreement must be reasonable. The plan must carry out its functions under the agreement in a responsible and prudent manner. As an example, obtaining Health Insurance claim numbers from beneficiaries should be accomplished through the mail or at the clinic at the time of a visit by the individual rather than by personal contact at the beneficiary's place of residence.

E. *Budget Preparation.*—Budgets are to be submitted in triplicate on the plan's stationery. An example of the budget format is contained in § 399, Exhibit 1. The budget must identify:

1. The official name and address of the organization as it appears on the agreement.
2. The Section 1874 agreement number.
3. The fiscal year for which funds are requested. Budgets must be for the governmental fiscal year, i.e., July 1 through June 30, even though this does not coincide with the plan's reporting period.
4. Whether the request is an initial or supplemental budget.
5. Each function assigned under the agreement.
6. The number of man-hours required to perform each function.
7. The personal service and other payroll related costs.
8. All other allowable costs not accounted for under personal services.
9. Total costs representing the sum of personal service and all other costs.
10. An estimated quarterly rate of expenditure as well as the total annual estimate.
11. Certification by a responsible official of the plan.

F. *Budget Justification.*—An essential part of the budget preparation process is the development of adequate explanatory material to support the estimates.

The plan should use its actual experience under the Medicare program as a point of departure in the development of the budget and justification of the budget estimates should be adequately explained.

Emphasis should be given to explaining the basis for allocation of indirect expenses to the Section 1874 contract. Direct labor ratios will generally be the most equitable basis for allocation. All costs associated with any underwriting service are considered as direct costs of the plan's regular business. Specifically, costs identified with selling, advertising, enrollment of new subscribers, collection of subscription income and group premium collections are unallowable costs.

Salaries of plan executives such as Director, Assistant Director, Administrator, etc., are considered as a part of care administration and are not reimbursable as a direct special cost to the Section 1874 agreement. A minor portion of such costs may be reimbursed as an indirect cost of the statistical reporting direct personal service costs. However, before such costs will be approved, an explanation of the function performed by the plan executive must be submitted.

For travel to be reimbursed under the Section 1874 agreement, it must be related to functions performed under the agreement and must be in accordance with the conditions set forth in Article V(D)(1) of the agreement. Whenever possible, plans should obtain prior approval from SSA.

G. *Budget Due Date.*—An original and one copy of the estimate and supporting justification should be submitted in time to be received in SSA by the first Monday in April preceding the fiscal year for which the budget request is made.

Budget material should be mailed to:

Social Security Administration
Bureau of Health Insurance
Attn: Division of Reimbursement
Baltimore, Maryland 21235

H. *Notice of Budget Approval and Limitations.*—After review of the budget by SSA, the plan will be sent written notice of the amount for its budget. In addition to the annual limitation placed on authorized expenditures, the notice of approval will establish limits on expenditures through the end of each fiscal quarter. The quarterly allocations will be cumulative in effect. Funds allocated for the first quarter, if not expended, would normally be reallocated in the second quarter, and so on.

I. *Periodic Analysis of Allotment.*—Each plan is responsible for periodically analyzing its budget in light of actual experience and projecting needs for the future. If at any time the plan has reason to believe that the amount of funds required for a special function will be greater than the estimate, the plan should notify the SSA in writing to that effect. The written notice will be in the form of a new estimate of special

costs together with a detailed explanation of the changes.

J. Billing SSA.—Costs incurred during the operating year are provisionally reimbursed on an estimated basis. Preferably, once each month, but not less frequently than each fiscal quarter, the plan requests payment for the allowable cost it has incurred or expects to incur in the performance of the assigned special functions. This request for payment is submitted in quadruplicate on the plan's letterhead stationery in the same format as the budget. (See § 399, Exhibit 2.)

No billing will be processed for payment without the following certification signed by a plan officer:

"I certify that the amount requested above represents necessary and proper costs incurred under Title XVIII of Public Law 89-97."

All billings should be mailed to the address shown in item G.

K. Final Cost Proposal.—No later than 90 days after the expiration of the plan's accounting year, the plan must submit a report of the actual costs incurred during the accounting period.

For those plans billing only direct costs, the final cost proposal will represent a summary of the actual costs billed during the accounting period. Since this "Final Cost Proposal" encompasses costs incurred in the plan's accounting year, the report may overlap two governmental fiscal years. Therefore, it is requested that a breakdown be included showing the costs incurred prior to June 30 and those incurred after July 1 of the plan's accounting year being reported. This "Final Cost Proposal" must be in the same format as the budget and accompanied by supporting data that identifies costs and explains the basis for allocating such costs. Additionally, the "Final Cost Proposal" must indicate the total number of SSA-1590's and/or 1591's submitted to the SSA.

The final cost proposal should be mailed to the address shown in item G.

L. Final Settlement.—Budgeting and interim cost reporting are designed to be flexible in view of the differences in accounting systems among plans. The final settlement of costs will be primarily based on an audit of the plan's records by the Department of Health, Education, and Welfare auditors. Plans must maintain supporting records and documentation of all costs claimed under the contract.

Procedures for Exchange of Information Between GPPP's and SSA

375. GENERAL

A. Since reimbursement for medical care is based on the number of Medicare beneficiaries who are members of the plan, it is necessary that these persons be identified on SSA records. To accomplish this, the plan must submit to SSA a list of the names of its members

who indicate they are covered under Part B of Medicare. This record must be updated monthly by submission of the names of persons who join or leave the plan or who attain age 65. (See § 376.)

B. The pro-rata amount to be credited to the beneficiary's deductible record as determined by the plan is that portion of the premium which the individual pays toward the deductible and coinsurance. This amount must be known by SSA and changes must be reported to it. (See § 318 for instructions on how to figure the pro-rata amount.)

Changes in a GPPP's pro-rata amount will be entered into social security records only on January 1 of *each calendar year* and will not be changed during that year. The new pro-rata amount will not affect the pro-rata amount credited to a member-beneficiary's deductible account for any months in the prior year. For example, if a plan which changed its pro-rata amount has a beneficiary accretion accepted by SSA during the current year with entitlement retroactive to a month in the prior year, the previous year's pro-rata amount is credited to the member-beneficiary's deductible account for the months in the previous year and the new amount is credited for the months in the current year.

For reporting changes in the prorata amount, see § 318.

C. Monthly reports (§ 380) showing changes in status of plan members will be furnished the plans provided the necessary authorizations for release of information have been submitted to SSA. (See § 384.) These monthly status reports are furnished principally for informational purposes to provide the plans a basis for determining capitation credits.

376. SUBMITTING ACCRETIONS AND DELETIONS

Plans should submit punched cards or magnetic tape accretions (with certification) and deletions on a regular monthly basis. These records should be shipped by the 15th calendar day of each month.

Plans having minimal workloads (less than 40 monthly transactions) and lacking machine facilities should submit this enrollment data in written form by completing Form SSA-1929, Group Practice Prepayment Plan Data Card Coding Worksheet (§ 399, Exhibit 6). This should be submitted by the first working day of each month. The form is designed so that when properly completed by the plan, it can be keypunched by SSA. Forms may be obtained from SSA or photocopied as needed.

All entries should be clearly handwritten in the appropriate prealigned spaces on the form. Block letters (CAPITALS) should be used for entries in the name fields.

SSA will return a monthly report of each accretion

and deletion record (see § 380) and indicate what disposition was made of the record, provided the plan has complied with the requirements outlined in § 376.1. This monthly report will show an acceptance or rejection record for every record the plan submitted in that shipment. SSA will submit the monthly reports in the format indicated by the plan.

IMPORTANT: Plans should never submit a deletion record unless they have received a notice from SSA that an accretion for that individual was accepted, i.e., the plan must receive a code "11" from SSA on an enrollee before submitting a code "51" on that individual. (See § 376.1 for a complete explanation of the data processing specifications for the exchange of data between SSA and GPPP as well as a complete explanation of the codes that will appear in the acceptance and rejection records.)

376.1 Specifications for the Exchange of Data Via Magnetic Tape, Punchcard or Form SSA-1929 Between SSA and GPPP's.—Each carton, tape reel or SSA 1929 must be labeled "GPPP (name of plan)" and mailed to:

Social Security Administration
Bureau of Data Processing and Accounts
Attention: EDP Branch, GPPP Unit
Baltimore, Maryland 21235

The following information is to be included when indicated:

Field	Item	Positions
1	HI Claim Number	1-12
2	Surname	13-24
3	First Name	25-31
4	Middle Initial	32
5	Sex (1-male, 2-female)	33
6	Date of Birth, (month, day, and year)	34-39
7	(Reserved—SSA)	40-46
8	GPPP Number	47-51
9	(Reserved—SSA)	52-59
10	SSA/GPPP Information— see § 376.2	60-67
11	(Reserved—SSA)	68-79
12	(blank or tape item record mark)	80

376.2 Explanatory Notes Regarding the Use of Fields Identifying the Individual's Health Insurance Record.—When an individual becomes entitled to health insurance benefits, he receives a health insurance card with his name, sex, health insurance claim number, and the effective dates of entitlement to hospital insurance and/or medical insurance. The social security district office may furnish a temporary health insurance eligibility notice when immediate medical service is needed before the health insurance card is issued.

Field 1. Health Insurance Claim Number:

SSA records are maintained by the individual's health insurance claim number and it is essential that the plan use it in all communications with SSA.

The Social Security Administration maintains the tape records for individuals enrolled in the health insurance program. However, there may be a "lag time" of up to 90 days between the time an individual enrolls in the health insurance program and the time his enrollment appears on the tape.

Both SSA and the Railroad Retirement Board issue health insurance cards. Most health insurance claim numbers are social security numbers with letter suffixes. The claim number may also be a Railroad Retirement Board number or social security number with letter prefixes.

1. Health Insurance Claim Numbers Assigned by SSA.—The social security number always consists of 9 digits divided into 3 parts and separated by hyphens: 000-00-0000. The first 3 digits are referred to as the area, the second 2 digits as the group, and the last 4 as the serial number. The area numbers range from 001 through 587 and from 700 through 728. Any combination of 2 digits, except "00," make up the group number. The last 4 digits of the social security number, the serial portion, run from 0001 through 999, and are repeated after each group.

The potentially valid SSA health insurance numbers are:

(a) SSA Claim Numbers

000-00-0000-A
000-00-0000-B, B1, B2, B3, B4, B5, B6, B9
000-00-0000-C1, C2, C3, C4, C5, C6, C7, C8, C9
000-00-0000-D, D1, D2, D3, D4, D5, D6, D7
000-00-0000-E, E1, E2, E3
000-00-0000-F1, F2, F3, F4, F5, F6, F7, F8
000-00-0000-HB, HB1, HB2, HB3, HB4, HB5, HB6, HB9
000-00-0000-HC1, HC2, HC3, HC4, HC5, HC6, HC7, HC8, HC9
000-00-0000-J1, J2, J3, J4 (See Note)
000-00-0000-K1, K2, K3, K4 (See Note)

Note: For J & K subscripts "3" and "4" there can be no entitlement to hospital insurance benefits. Supplementary medical insurance entitlement may exist for all J and K suffixes.

(b) Special SSA Health Insurance Only Claim Numbers.—Some individuals who are not entitled to social security old-age, survivors, or disability insurance benefits, or qualified for railroad retirement, are entitled to health insurance benefits. They have social security numbers with these suffixes:

000-00-0000-T
000-00-0000-M, M1

The suffix letter T indicates the individual is entitled to hospital, or hospital and medical insurance. Suffix letters M and M1 indicate the individual is entitled to medical insurance benefits, but not to hospital insurance benefits.

2. Health Insurance Claim Numbers Assigned by the Railroad Retirement Board.—The RRB began using the social security number in its numbering system during 1964. The numbers assigned prior to that time are 6-digit numbers and were assigned in numerical sequence; they have no special characteristics. However, the 6-digit numbers and the 9-digit social security numbers, when used as claim numbers by the RRB always have letter prefixes. (In rare cases, a qualified railroad retirement beneficiary may have a claim number with less than 6 digits; sufficient zeros should be added between the prefix and other digits to make a 6-digit number, e.g., WD-001234.)

6 digit numbers

The highest number assigned is known and is different for each group of prefixes as follows:

Prefixes	Numbers Assigned
A, MA, WA, WCA, PA, JA	000001-991273
WD, WCD, PD	000001-415935
H, MH, WH, WCH, PH	000001-049159

All Inclusive List of Potentially Valid RRB Health Insurance Claim Numbers

A-000000, or	PA-000000, or
A-000-00-0000	PA-000-00-0000
MA-000000, or	PD-000000, or
MA-000-00-0000	PD-000-00-0000
WA-000000, or	H-000000
WA-000-00-0000	
	MH-000000
WD-000000, or	
WD-000-00-0000	WH-000000
WCA-000000, or	PH-000000
WCD-000-00-0000	
	JA-000000

3. Explanation of SSA Sequence for Transmitting Data.—SSA files are always in basic nine-digit numeric sequence in high order position followed by claims symbols. The order position on RRB HI claims numbers are always zoned left. All six-digit numbers appear first in sequence followed by nine-digit SS numbers. For sequential purposes, the RR prefix is dropped. Below is an example of how these numbers would appear in sequence on a data transmission from SSA. You may wish to retain your files in the same sequence in order to facilitate transmission in both directions.

Sequential Order Appearing on Transmittal	Type of Number
WCA123456	RR

A234567	RR
A001208318	RR
MA001208318	RR
WCA123456789	RR
A723184567	RR
MA723184567	RR
001208321A	SS
183205421A	SS
183205421B	SS

Field 2. Surname.—Twelve positions are provided in the surname field. If fewer than 12 positions are needed, blanks should be used to complete the field. In cases of a compound surname, the name should appear as it does on the beneficiary's health insurance card. If the surname consists of more than 12 characters, only the first 12 characters should be shown; otherwise, the surname would overlap into the first name field. However, a blank should be inserted between the surname and a designation of "JR" or "SR."

Field 3. First Name.—The same considerations that apply to field 2 apply to field 3. However, only seven positions are available for the first name.

Field 4. Middle Initial.—Self explanatory.

Field 5. Sex.—Self-explanatory. The purpose of this field is to provide a basis for checking the validity of the claim number.

Field 6. Date of Birth.—Six spaces are provided for date of birth. Show month, day, and year, e.g., January 25, 1901, would be shown 012501. If the date of birth is unknown, this field should be left blank. This field provides a basis for checking the validity of the claim number.

Field 7. Reserved to SSA.—SSA uses field 7 (positions 40-46) for its own internal data processing requirements. If any information is shown in this field by GPPP, it will be dropped when it enters the system but it would not adversely affect SSA's processing.

Field 8. Plan Number.—The plan number as assigned by SSA should be entered by the plan on all transactions—initial identification, accretions, deletions, and other items as assigned.

Field 9. Reserved for SSA.—SSA uses field 9 (positions 52-59) for its own internal data processing requirements. If any information is shown in this field by GPPP, it will be dropped when it enters the system but it would not adversely affect SSA's processing.

Field 10. Exchange of Information.—Field 10 is used to convey information between SSA and GPPP. The first two characters in this field, positions 60-61, will be a numerical code to describe

a transaction. (See numerical codes below.) The effective date (month and year) of the transaction will be shown as the last four characters of the field, positions 64–67. In the event that a certain transaction is not processed, SSA will show a non-process code in positions 60–61 (see numerical codes below) and will show the GPPP transaction code (initially reported in positions 60–61) in positions 62–63. In all other instances, positions 62–63 will contain blanks.

EXAMPLE: A plan sends SSA data indicating that an individual is enrolled in the plan and eligible for Part B benefits effective August 1, 1967. This information would read as “61~~1~~0867” in positions 60–67.

SSA records show that the individual’s record is not in file. The transmittal from SSA would read, “27610867” in positions 60–67.

Various numerical codes are used to describe the various situations that occur. SSA will use codes 01–49 to communicate to GPPP. GPPP will use codes 50–99 to communicate to SSA. As additional codes (01–99) become necessary, SSA will assign them since there is a need to coordinate these codes at one central location. If there is need for additional codes, the plans are to contact SSA, describe the situation, and the codes will be assigned. Current codes that are applicable are as follows:

a. From GPPP to SSA:

- 51: *Deletion from GPPP.* This code will be followed by two blanks and the month and year of deletion (e.g., if an individual was entitled to plan benefits in March 1967 and was no longer entitled to benefits in April 1967, 51~~1~~0467 would be shown in positions 60–67).
- 61: *Accretion to GPPP.* This code will be followed by two blanks and the effective month and year of enrollment in the plan (e.g., an accretion effective November 1966 would be shown as 61~~1~~1166 in positions 60–67).

b. From SSA to GPPP:

- 11: *Accretion to plan.* This code will be followed by a Part A indication code, a blank, and the effective month and year of plan membership or Part B enrollment—whichever is later. An “A” in position 62 will indicate entitlement to Part A coverage; a blank in position 62 will indicate no entitlement to Part A coverage (e.g., 11A~~1~~0966) in positions 60–67 will tell GPPP that this person has Part A coverage and is a member of the plan, or is entitled to Part B coverage effective September 1966).
- 16: *SSA termination notice.* This code will be followed by two blanks and the effective month and year of Part B termination (e.g., 16~~1~~0768 in positions

60–67 would mean that Part B coverage was terminated effective July 1968).

This code is generated when SSA Master Benefit Records show that the individual’s benefits are terminated due to nonpayment of premiums. It is *not* generated when termination is due to death.

- 17: *Deletion from plan.* This code will be followed by two blanks and the month the individual’s membership in the plan or Part B coverage terminated, whichever is earlier. This code is furnished in response to an acceptable code “51” record received from the plan.
- 18: *SSA termination notice due to death.* This code will be followed by two blanks and the effective month and year of termination. This date will be the month following the month of death (e.g., 18~~1~~0768 in positions 60–67 would mean that the individual died in June 1968 and that Part B coverage was terminated effective July 1968).
- Periodically, SSA will submit to each plan a preliminary list of members who are shown on SSA’s annotated membership record for the plan and who are identified by SSA as deceased beneficiaries. This code will be generated for each individual on the list for whom SSA did not receive contrary information from the plan within 30 days.
- 23: *Claim number change.* The old number will appear in field 1 (positions 1–12). The new number will appear in field 11 (positions 68–79). This code will be followed by two blanks and the month and year the new number was effective (e.g., 23~~1~~0367 in positions 60–67 would mean that the new claim number was effective March 1967).
- 24: *Invalid transaction date.* This code will be followed by the original code and effective date furnished by the GPPP to denote that the effective date furnished by the GPPP is a date in the future (e.g., 24610170 in positions 60–67 would mean that accretion effective January 1970 is in advance of the current processing period).
- 25: *Duplicate transaction—same plan.* This code will be followed by the original code and effective date furnished by the GPPP to show a duplicate of a prior notification (e.g., 25610966 in positions 60–67 means that this accretion had been previously reported by the same plan and was already shown on the HI master record).
- 26: *Duplicate transaction—different plan.* The code is used when two plans have submitted transactions involving the same individual. The first transaction will be processed against the HI master file. The second transaction will receive this code. The code will be followed by the original code and effective date furnished by the GPPP to show a

duplicate of a prior notification (e.g., 26610966 in positions 60–67 means that a previous transaction had been reported by a different plan prior to the September 1966 effective date shown by the second plan).

The GPPP number that is already recorded on the HI master tape will be shown in positions 71–75.

27: Not in file. This code will be followed by the original accretion or deletion code furnished and the effective date furnished by the GPPP to denote that we have no record established for the HI claim number furnished. (See § 376.2.)

28: Name difference. This code will be followed by the original accretion or deletion code and the effective date furnished by the GPPP to denote that we have a record established for the HI claim number furnished, but the first six characters on the HI master record do not match the first six characters on the record furnished by the plan. (See § 376.2.)

29: Not enrolled for Part B, but is entitled to Part A. This code will be followed by the original accretion code and effective date furnished by the GPPP to denote that we have no record of Part B enrollment for the person identified as a GPPP accretion (e.g., 29610966 in positions 60–67 would mean we have no Part B enrollment data for the person that the GPPP is identifying as an accretion to the plan effective September 1966). (See § 376.2.)

Field 11. Reserved for SSA.—This is reserved for internal SSA use. If the individual's claim number is changed by SSA, SSA will show the old claim number in this field. (See code 23 in field 10, above.)

Field 12. Blank. A blank or tape item record mark should be entered in position 80.

378. MAGNETIC TAPE RECORD CONTENTS AND FORMATS

A. Tape Data Records.—Tape records may be single 80 position items or preferably, a block of ten 80 position items. If the last tape block is not full, 9's as pad items (with a terminating record mark) shall be added to fill the last block.

Data must be recorded in binary coded decimal, alpha mode. Recording density may be 200, 556 (preferably), or 800 characters per inch.

B. Header and Trailer Labels.—Header and trailer labels will be required. The header and trailer labels should be at least 80 but not more than 95 characters in length. The trailer label shall be preceded and fol-

lowed by a tape mark. There will be no tape mark between a header label and the following data records.

1. Header Label Format is as follows:

Field	Contents	Description	Positions
1	(blank)	Constant-Header Label	1
2	GPPP	Tape File Code-Group Practice Pre-Payment Plan	2–5
3	(blanks)	Constant	6–11
4		GPPP Number	12–16
5	(blanks)	Constant	17–19
6		Blank or Date-Month day and year	20–25
7	(blank)	Constant	26
8	000	Reel Number	27–29
9		Blank or Miscellaneous Data (at your option)	30–79
10	‡	Record Mark	80

2. Trailer Format is as follows:

Field	Contents	Description	Positions
1	lead	Constant-Trailer Label	1–4
2	(blank)	Constant	5
3	"R" or "F"	R—end of reel, other than last reel F—end of reel, last reel	6
4	000000	Item Record Count for Reel	7–12
5		Blank or optional Data	13–79
6		Record Mark	80

379. PROBLEM CASES CONCERNING PART B ENTITLEMENT.—Some GPPP's have experienced problems in determining Part B eligibility for individual members. Members of a GPPP must be properly identified in order to annotate the SSA records to determine eligibility for SML (See § 376ff. for a detailed description of the procedure.) Before submitting code 27 (not in file), code 28 (name difference), or code 29 (not entitled to Part B) cases to SSA for resolution, the plan must take the necessary steps to verify that the information submitted to SSA is correct. Once this information has been verified, a letter requesting resolution of the case in question should be sent to:

Social Security Administration
Bureau of Data Processing and Accounts
6401 Security Boulevard
Baltimore, Maryland 21235
Attn: EDP Branch, GPPP Unit

This letter should contain all pertinent facts, including the individual's name and health insurance number, his or the plan's allegations, and any other

information which may be useful. If possible, copies of all correspondence should be included.

There are four basic reasons for rejection of accretion items:

1. Name and claim number submitted do not agree (the claim number does not belong to the named individual);
2. No claim to establish Part B eligibility has been filed;
3. Claim to establish Part B eligibility is still in process in SSA's claim system;
4. Claim for Part B eligibility has been disallowed.

The following are the procedures to resolve discrepant items:

1. Recheck plan records to determine if the claim number and name were furnished correctly. If either the number or name were furnished incorrectly, the plan should resubmit, with the correct information, as a new accretion, giving the regular accretion code (61) and the original effective date.
2. When a plan cannot reconcile the item from its own records, it should contact the member to determine if the data originally furnished was correct. If either the number or name was furnished incorrectly, the plan should resubmit, with the correct information, as a new accretion, giving the regular accretion code (61) and the original effective date.
3. Once it has been verified that the information was correctly submitted, a letter requesting resolution of the case should be sent to the address given above.

As soon as a determination is made, the plan will be notified. In the small percentage of cases where additional investigation with other SSA components is required, there will be a delay in responding with a final decision. In such cases, the plan will be advised that referral action has been taken.

380. MONTHLY REPORTS

There are two preliminary conditions which must be satisfied before SSA can send the plan Monthly Reports on its enrollees. First, the plan must have sent SSA the pro rata amount to be credited toward the Part B deductible. Second, the plan must have secured disclosure authorizations from its members and have certified to SSA that these are on file (See § 384.)

SSA will send the plan a Monthly Report as outlined in § 380.1 whenever there is a change in the status of any of its members.

380.1 Sequence, Format, and Content of Monthly Reports.—Monthly Reports will be in HI number sequence and reflect changes in status (i.e., accretions and deletions), claim number changes, and reject items.

The reports will be furnished on punched cards, magnetic tape, and/or computer printed "hard copy" as requested by the individual plan.

Reports in punched card form will follow the format described in § § 376.1 and 376.2.

Reports on magnetic tape will have the date positioned in the same format as for punched cards; however, the records will be grouped ten items to a block, with 80 characters per item. In the event that the last block appearing on the tape contains less than ten items, the remaining items in the block will be padded with "9's" with a terminal record mark for each item.

Reports in hard copy format will follow the format described in § § 376.1 and 376.2

382. BRIEF EXPLANATION OF SSA SYSTEM FOR MAINTAINING PART B DEDUCTIBLE AND REIMBURSEMENT

In order to understand the information in SSA records, it is necessary for the plan to know how SSA makes Part B payments through its carriers and fiscal intermediaries. The process is as follows:

A. The area carrier receives claims from beneficiaries and physicians, laboratories, and others who furnish medical services or supplies. The fiscal intermediary receives Part B billing forms from providers of services for outpatient services, Part B and medical and other health services, and home health agency services.

B. The area carrier or fiscal intermediary then checks with SSA to see what portion of the Part B deductible has been satisfied for the year in which the expenses were incurred. This is done by "querying" SSA records. *The "query" includes the amount of the expense incurred and is used to update the beneficiary's deductible amount.*

Once the area carrier or fiscal intermediary knows that the Part B deductible, as reflected on SSA records, is satisfied, it can make payment on subsequent claims for the year in question without again querying SSA records.

C. The area carrier sends a payment record to SSA after it pays the claim. The fiscal intermediary sends a copy of the billing form to SSA after it makes payment. The payment record (or billing form) is used to update the Part B reimbursement amount recorded for the beneficiary.

Since the deductible record is updated on the basis of queries submitted before payment is made, it is generally current. However, it reflects only Part B expenses credited toward the deductible.

Since the reimbursement record is updated after payment is made and the maintenance of this record is not critical to the payment of benefits, there may be a lag of several months between the time payment is made and the time the amount appears in SSA's records.

384. AUTHORIZATION FOR RELEASE OF INFORMATION

A. Authorization for Release.—The plan must secure a statement from each member whose name and health insurance claim number is forwarded to the Administration authorizing SSA to furnish information to the plan about his health insurance entitlement and Part B benefits usage. This authorization is to be retained in the plan files. (See § 130 C.)

MODEL AUTHORIZATION FOR RELEASE OF INFORMATION TO A GPPP DEALING DIRECTLY WITH SSA

I HEREBY AUTHORIZE the Social Security Administration to furnish information to . . . (name of plan) . . . affirming my entitlement to Hospital Insurance Benefits (Part A) and enrollment for Supplementary Medical Insurance Benefits (Part B) under Title XVIII of the Social Security Act.

I ALSO HEREBY AUTHORIZE the Social Security Administration to furnish the plan information as to Part B benefits recorded, including those based on services not furnished by or through the plan, and should my enrollment under Part B be terminated, the effective month of such termination for its use in connection with the operation of this plan.

(Signature) _____
(Date) _____

B. Certification that GPPP has member authorization to release information.—The plan must certify to the Administration at the time it forwards the member's name and number that it has obtained the required authorization from him and that such authorization is in its files. The certification should accompany the shipment.

MODEL CERTIFICATION THAT GPPP HAS MEMBER AUTHORIZATION FOR DISCLOSURE OF INFORMATION—FOR TRANSMITTAL WITH SHIPMENT

THIS IS TO CERTIFY THAT . . . (name of GPPP) . . . has in its possession a properly executed authorization for disclosure of information for each individual identified as a plan member which permits the Social Security Administration to release to the plan verification of the individual's Part A entitlement, Part B enrollment, and furnish other Part B data relating to the individual, and that such authorization is available, upon request, for examination by the Administration.

(Signature) _____
(Title) _____
(Date) _____

This certification, with the shipment of records, should be sent to the address shown in § 376.1.

388. GROUP PRACTICE PREPAYMENT PLANS DEALING DIRECTLY WITH SSA

<i>State</i>	<i>GPPP Number</i>	<i>Office</i>
CALIFORNIA	90-050	Family Health Program of Southern California 2925 North Palo Verde Avenue Long Beach, California 90815
	91-050	Kaiser Foundation Health Plan 4900 Sunset Boulevard Los Angeles, California 90027
	91-051	Kaiser Foundation Health Plan 1924 Broadway Oakland, California 94612
	90-052	La Societe Francaise de Bienfaisance Mutuelle 4131 Geary Boulevard San Francisco, California 94118
	90-053	Santa Fe Employees Hospital Association—Coast Lines 610 South St. Louis Street Los Angeles, California 90023
	90-054	Southern Pacific Employees Hospital Association 1400 Fell Street San Francisco, California 94117

<i>State</i>	<i>GPPP Number</i>	<i>Office</i>
DISTRICT OF COLUMBIA	90-091	United Mine Workers of America Welfare and Retirement Fund 907 Fifteenth Street NW Washington, D.C. 20005
HAWAII	91-120	Kaiser Foundation Health Plan 1697 Ala Moana Boulevard Honolulu, Hawaii 96815
ILLINOIS	90-140	Wabash Memorial Hospital Association 360 East Grand Avenue Decatur, Illinois 62525
KANSAS	90-170	AT & SF Employees' Benefit Association 417 E. 6th Street Topeka, Kansas 66607
MICHIGAN	90-230	Community Health Association 13936 Woodward Avenue Highland Park, Michigan 48203
MINNESOTA	90-240	Group Health Plan, Inc. 2500 Como Avenue St. Paul, Minnesota 55108
MISSOURI	90-261	Medical Institute of Local 88 4488 Forest Park Avenue St. Louis, Missouri 63108
	90-264	St. Louis Labor Health Institute 300 S. Grand Boulevard St. Louis, Missouri 63103
NEW YORK	90-331	Boro Medical Center 104 Fifth Avenue New York, New York 10011
	90-332	Health Insurance Plan of Greater New York 625 Madison Avenue New York, New York 10022
	90-330	Local 1205 Health Center 615 Fourth Avenue Brooklyn, New York 11215
	90-333	NYSA-ILA Coordinating Committee 17 Battery Place New York, New York 10004
	90-335	NYSA-PWU Welfare Fund 80 Broad Street New York, New York 10004
	90-334	Union Family Medical Fund of the Hotel Industry of New York City 707 8th Avenue New York, New York 10036
OREGON	91-380	Kaiser Foundation Health Plan 5050 North Greeley Avenue Portland, Oregon 97217
OHIO	90-360	Kaiser Community Health Foundation 5510 Pearl Road Cleveland, Ohio 44129

<i>State</i>	<i>GPPP Number</i>	<i>Office</i>
PENNSYLVANIA	90-390	Philadelphia AFL-CIO Hospital Association Langdon Street and Cheltenham Avenue Philadelphia, Pennsylvania 19124
	90-391	Police and Fireman's Medical Association Langdon and Howell Streets Philadelphia, Pennsylvania 19149
	90-500	Group Health Cooperative of Puget Sound 200 15th Avenue, East Seattle, Washington 98102
WASHINGTON	90-501	Western Clinic 6th Avenue and South "K" Street Tacoma, Washington 98405

Statistics

390. UTILIZATION AND STATISTICAL REPORTING

A. How Statistics Will Be Collected.—All basic recurrent program statistics will be collected and compiled centrally by the SSA. GPPP's will not be required nor expected to tabulate and prepare routine statistics.

Basic program statistics for GPPP's dealing directly with the SSA will be compiled by SSA from reporting forms submitted by the plans at least monthly. GPPP's will prepare these forms showing all covered Part B services utilized during the reporting period by each of their members who are enrolled in the Supplementary Medical Insurance Program, and will send them to Baltimore. Samples of the SSA-1590 and SSA-1591 forms and specific directions for their completion are shown in § 399, Exhibits 3 and 4.

B. Completing the Reporting Forms.—SSA has developed alternate forms that GPPP's will use in reporting utilization of all services covered under the Part B program. One is a listing-type form, form SSA-1590, Group Practice Plan Utilization Listing of Social Security Medical Insurance Services (§ 399, Exhibit 3), on which all the covered services furnished to all plan members who are eligible for Part B services are to be reported. The other type of form, form SSA-1591, Group Practice Plan Individual Patient Utilization Report of Social Security Medical Insurance Services (§ 399, Exhibit 4), is filled out on an individual member basis for all services furnished to that individual by the GPPP during the reporting period. A plan can complete whichever of the two forms best fits its mode of operation.

GPPP's that use both the SSA-1590 and SSA-1591 forms for reporting should notify SSA of the reasons that both type of forms are being used.

One of the forms must be completed by every GPPP dealing directly with SSA. Both of the reporting forms are designed to capture basic utilization information

under the Part B program for individual beneficiaries. Each plan should report on these forms all items of service covered under Part B. Services covered under Part A and noncovered services not included in this per capita reimbursement cost base are not to be entered on these statistical reports of service forms.

C. Coding Required on Report of Service Forms.—

1. GPPP's will not be required to code procedures or diagnoses on the utilization reporting forms. However, for each covered service furnished to a plan member under Part B that involves a visit to a physician, the report of that service must show the specialty of the physician (as defined by the physician or by the plan) furnishing the service. A visit to a physician is defined as a formal face-to-face contact between the physician and the patient for purposes of diagnosis or treatment. The 2-digit codes to be used for physician specialty are:

Physician's Specialty Codes

<i>Code</i>	<i>Specialization</i>
01	General Practice
02	General Surgery
03	Allergy
04	Otology, Laryngology, Rhinology
05	Anesthesiology
06	Cardiovascular Disease
07	Dermatology
08	Family Practice
09	Gynecology (Osteopaths only)
10	Gastroenterology
11	Internal Medicine
12	Manipulative Therapy (Osteopaths only)
13	Neurology
14	Neurological Surgery
15	Obstetrics (Osteopaths only)
16	OB—Gynecology
17	Ophthalmology, Otology, Laryngology Rhinology (Osteopaths only)
18	Ophthalmology
19	Oral Surgery (Dentists only)

<i>Code</i>	<i>Specialization</i>
20	Orthopedic Surgery
21	Pathologic Anatomy, Clinical Pathology (Osteopaths only)
22	Pathology
23	Peripheral Vascular Diseases or Surgery (Osteopaths only)
24	Plastic Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Psychiatry, Neurology (Osteopaths only)
28	Proctology
29	Pulmonary Diseases
30	Radiology
31	Roentgenology, Radiology (Osteopaths only)
32	Radiation Therapy (Osteopaths only)
33	Thoracic Surgery
34	Urology
48	Podiatrist (Surgical Chiropraxy)
49	Miscellaneous
99	Unknown

Individual physicians will be considered specialists if they so classify themselves regardless of whether or not they are certified by specialty boards.

2. Many services provided by plans to members who are Part B beneficiaries will *not* involve a "visit" to a physician. Examples are taking of a blood sample and subsequent testing by a laboratory technician, x-ray of a patient's chest by an x-ray technician and subsequent interpretation of the film by a radiologist, etc. For each such item of service reported on the utilization reporting form, type of service will have to be identified using the following type of service code:

- 71—Diagnostic X-ray
- 72—Diagnostic Laboratory
- 73—Physiotherapy
- 74—Occupational Therapy
- 75—Other Medical Care

3. Laboratory procedures should be reported by date of each service using the following descriptive categories:

Hematology	Feces Examinations
Blood Chemistry	Gastric Analysis
Virology	Spinal Fluid Exams
Serology	Sputum Exams
Urinalyses	Tissue Studies
Clinical Microscopy	

For example, if a series of blood tests such as a CBC, a hematocrit, and a sedimentation rate for an individual patient were all given on the same date, they would be reported collectively as "hematology." This would require only one line of information on form SSA 1590 or 1591 instead of three lines. Other tests such as EKG, Radioisotopes, Audiometric Testing, and Pulmonary Function Studies still need to be specified as would any other tests not falling into the categories listed above.

In reporting x-ray procedures for an individual patient given on a specific date, it is only necessary to report the body part involved. It is not necessary to report the number of views or plates taken. For example, if an individual patient on a given date had a chest x-ray and an x-ray of the shoulder, two lines would be completed on the SSA-1590 or 1591 showing "X-ray chest" on one line and "X-ray shoulder" on the second line.

4. In some instances, GPPP's will refer members to medical suppliers other than physicians (and other than institution providers) for services. These include referral to a medical supply house for rental or purchase of medical equipment, a certified orthotist for fitting of an artificial limb, etc. Where the plan rather than the member pays for such services, they will be reported on the utilization and statistical report forms. For each such item, the report form must identify the type of supplier involved using the following 2-digit codes:

<i>Code</i>	<i>Type of Supplier</i>
51	Medical supply company with C.O. (Certified orthotist—certified by American Board for Certification in Prosthetics and Orthotics) certification
52	Medical supply company with C.P. (Certified prosthetist—certified by American Board for Certification in Prosthetics and Orthotics) certification
53	Medical supply company with C.P.O. (Certified prosthetist—orthotist—certified by American Board for Certification in Prosthetics) certification
54	Medical supply company not included in 51, 52, or 53
55	Individual CO
56	Individual CP
57	Individual CPO
58	Individual not included in 55, 56, or 57
59	Ambulance service supplier, e.g., private ambulance companies, funeral homes, etc.
60	Public Health or Welfare Agencies (Federal, State, Local)
61	Voluntary Health or Charitable Agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities, Inc., etc.)
62	Psychologist
63	Portable X-ray Supplier
64	Audiologist
69	All other, e.g., Drug and Department Stores (trusses)
88	Unknown

D. *Sending Completed Report of Services Forms to SSA.*—At least once every 4 weeks the report of service forms should be sent to SSA. Before shipment,

the forms should be batched in batches of up to 100 forms. However, timely transmittal is more important than the number of forms included, so a batch may include less than 100 forms. SSA-1590 and SSA-1591 forms may never be mixed together in one batch.

Each shipment of forms must be sent under cover of a transmittal, form SSA-1575 to:

Social Security Administration
Bureau of Data Processing and Accounts
Civic-Howard Building
211 West Lombard Street
Baltimore, Maryland 21201
Attention: Medical Insurance

The SSA-1575 is a snap-out form. (See § 399, Exhibit 5.) The original should be forwarded with the shipment and the duplicate maintained by the GPPP. Enter the following information on the SSA-1575:

a. GPPP's identification number (this is entered in the space labeled Intermediary Number).

b. GPPP's name and address.

c. Date batched (this is the date the GPPP forwards the shipment to SSA).

d. Batch number—A consecutively assigned 3-digit number beginning with 001 and running through 999, and then repeated. If a GPPP has more than one paying office submitting records directly to SSA, each individual office must maintain separate consecutive batch numbers for records it submits.

e. Total number of items—If the GPPP is using the listing type form (SSA-1590) show the total number of pages and the number of line items included in the shipment, e.g., 90 pages, 1,515 lines completed. If a GPPP is using the individual patient summary form (SSA-1591) show the number of forms being transmitted for different individuals. If more than one SSA-1591 is used for a given individual, staple the forms together and count as one form for the purpose of the item count.

f. Type of records—Indicate either SSA-1590 or SSA-1591 on the transmittal. *Each type of form should be batched and transmitted separately.*

E. Corrections to Previously Submitted Report of Services Form.—Occasionally, it may be necessary to correct information previously submitted on a SSA-1590 or 1591 form. For example, a plan may discover that some services were submitted twice and must notify SSA to delete one of the reports, or may realize that some services reported to SSA were not covered, or find out that an individual for whom a SSA-1590 or 1591 was submitted was not eligible for Part B benefits. Whenever these or similar situations occur, the GPPP should submit a correction to SSA. A new SSA-1590 or 1591 form should be completed showing the information to be corrected exactly as it was originally reported, the annotation "correction"

should be shown in the upper right corner of the form, and a description of the correction required should be entered on this form (e.g., delete services shown because they are noncovered, delete all services because persons ineligible, etc.). Enter only the incorrect information on the "corrected" SSA-1590 when *part* of the information on the original form is to be corrected. For example, if only one person's services are to be deleted from a previously submitted SSA-1590 form showing services for several persons, the "corrected" SSA-1590 should show only the services for the person that is to be deleted. All such correction forms should be grouped together at the back of a regular batch transmittal.

F. Statistical Report Deletion Process.—SSA will return to GPPP's for correction forms SSA-1590 and SSA-1591 which cannot be processed because they do not meet the reporting requirements. The following are reasons for which a form will be returned to a GPPP:

1. Health insurance claim number is missing, incomplete, or invalid.

2. Services furnished are not described clearly or specifically.

3. Date of service is missing.

4. Place of service is missing.

5. Physician specialty code is missing, unidentifiable, or invalid.

6. Nature of illness or injury treated is missing. Individual SSA-1590 and 1591 forms will be accepted with this item missing. However, if this item is omitted on a large number of cases and it is apparent the GPPP is making no effort to enter it, these forms will be returned.

7. Copies of SSA-1590 or 1591 are illegible.

8. Necessary information on forms is lined out or otherwise obliterated.

9. GPPP number is missing.

Forms returned to a GPPP will be accompanied by the transmittal form SSA-1575 which accompanied the original batch submitted to SSA. A line item under the "Bills Deleted for Return to Intermediary" will be completed for each form returned. The health insurance claims number of each entry being deleted and the reason(s) for the deletion will be shown. In addition, any other information such as line, page, date of service, etc., which is needed to uniquely identify the deleted item will be shown. The reason(s) for returning the form will be shown as codes 1-13 and the reasons entered in the "Additional Information Required" column of the SSA-1575. Deletions reasons 1-13 are briefly described in the code legend on the August 1967 revision of the SSA-1575 (see § 399, Exhibit 5), and include the reasons described above. Not all of the codes 1-13 will be applicable to forms SSA-1590 and 1591 since this transmittal is also used

with other statistical reports. It is suggested that all cases be checked for completeness and conformance to specifications before shipment to SSA.

G. The GPPP should make the necessary corrections to the form(s) returned by SSA. The corrected forms should be resubmitted to SSA in the following manner:

1. Batch the forms being returned (from one or more returned groups) into a new batch of 25 or less forms. Prepare a new transmittal and assign a new batch number. Do not mix the forms returned for correction with forms being sent for the first time. Do not mix SSA-1590 and SSA-1591 forms in the same batch. In the "Type of Bills" block enter "Deletions Returned" along with the SSA form number.

2. Attach the old transmittal(s) (those that list the HI claim numbers and reasons for return to the GPPP) to the new transmittal form.

3. Multiple forms originally returned to a GPPP under one transmittal must be returned to SSA together in the same new batch.

4. Submit the corrected forms to the same address as original submittals.

NOTE: If a GPPP questions the reason(s) for returning one or more forms, it should send the returned transmittal sheet and all forms listed on it (including those not in question) with comments to the following address:

Social Security Administration
Health Insurance Statistics Branch
P.O. Box 1433
Baltimore, Maryland 21203
Attention: Deleted Bills

After resolution of the question raised, the forms and reply will be sent back to the GPPP for submittal to SSA.

SSA will maintain a control to assure cases returned to the GPPP for correction are resubmitted and will follow up regarding claims that have not been resubmitted within 30 days.

399. EXHIBITS

1. GPPP Budget Format.

2. GPPP Request for Payment.

3. Form SSA-1590: GPPP Utilization Listing of Social Security Medical Insurance Services; Instructions for Completing.

4. Form SSA-1591: GPPP Individual Patient Utilization Report Form of Social Security Medical Insurance Services; Instructions for Completing.

5. Form SSA-1575: Advice of Transmittal—Medical Insurance Statistical Sample.

6. Form SSA-1929: GPPP Data Card Coding Worksheet.

EXHIBIT 1

GPPP Budget Format

Plan's Name and Address

Contract No. ----

Estimate of Cost for the period ----- through -----

<i>Functions</i>	<i>Man Hours</i>	<i>Personal Service Cost</i>	<i>Other Cost</i>	<i>Total Cost</i>
Identification of Medicare Beneficiaries -----	XX	\$XXX	XXX	XX
Statistical Reporting -----	XX	XXX	XXX	XX
Other (Identify) -----	XX	XXX	XXX	XX
-----	XX	XXX	XXX	XX
Totals -----	XXX	XXX	XXXX	XXX

Schedule of Estimated Expenditures:

1st Quarter, ending September 30	\$-----
2nd Quarter, ending December 31	\$-----
3rd Quarter, ending March 31	\$-----
4th Quarter, ending June 30	\$-----

I certify to the best of my belief or knowledge this data is accurate, complete, and current as of the date of the execution of this certificate.

Signature of Certifying Officer

EXHIBIT 2

GPPP Request for Payment

Plan's Name and Address

Contract No. ----

Invoice of Cost for the period ----- through -----

<i>Functions</i>	<i>Man Hours</i>	<i>Personal Service Cost</i>	<i>Other Cost</i>	<i>Total Cost</i>
Identification of Medicare Beneficiaries -----	XXX	\$XXXX	XXX	XXX
Statistical Reporting -----	XXX	XXXX	XXX	XXX
Other (Identify) -----	XXX	XXXX	XXX	XXX
Other (Identify) -----	XXX	XXXX	XXX	XXX
Totals -----	<u>XXX</u>	<u>XXXXX</u>	<u>XXX</u>	<u>XXX</u>

I certify that the amount
requested above represents
necessary and proper costs
incurred under Title XVIII
of Public Law 89-97.

Signature of Certifying Officer

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
NEW YORK STATE
OFFICE OF GENERAL SERVICES

Form Approved
Budget Bureau No. 72-R751

GROUP PRACTICE PLAN UTILIZATION LISTING OF SOCIAL SECURITY MEDICAL INSURANCE SERVICES			NAME OF PLAN		PLAN ID NUMBER	TIME PERIOD COVERED BY REPORT	NUMBER	PAGE	OF
HI CLAIMS NUMBER (1)	NAME OF PATIENT (2)	DATE OF SERVICE 19____ (3)	PLACE OF SERVICE (4)	PHYSICIAN SPECIALTY OR TYPE OF SUPPLIER OR SERVICE (5)	SURGICAL OR MEDICAL PROCEDURES OR SUPPLIES FURNISHED (6)	NATURE OF ILLNESS OR INJURY (INCLUDING SERVICES (DIAGNOSIS) (7)			
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13.									
14.									
15.									
16.									
17.									

CERTIFICATION: The signature of the Plan Official certifies the services were rendered as listed.

SIGNATURE OF PLAN OFFICIAL (needed on first page only)

DATE

FORM SSA-1590 (6-66)

**Instructions for Completing Group Practice Plan Utilization Listing (Form SSA-1590)—
Supplementary Medical Insurance Services**

At top of the form enter the following information in the spaces provided:

1. Name of the GPPP
2. Identification number assigned to the GPPP by the SSA (5-digit number)
3. Time period covered by the form (month and day, e.g., August 1–August 31)
4. Plan control number (a file control or reference number if the plan uses one)
5. Page number, e.g., 1 of 4; 2 of 4, etc.

To report the services furnished to Part B eligibles each month, the plan should complete as many pages of this form as are necessary to report all covered services furnished during the time period covered. The signature of the plan official on the bottom of the form is needed only on the first page. The plan control number box on the top of the form is for the convenience of GPPP's in identifying the individual file location point for the records of the persons shown on the form. If such a number is needed by the GPPP to locate the original record, enter it in this space. If none is needed, leave this space blank.

One line on the form should be completed for each covered service furnished to a Part B beneficiary during the time covered by the report. Beneficiaries who receive two or more separate services (including the same service on different dates) should appear as many times as they were furnished services. Similarly, a beneficiary who receives more than one specific service on one date must also appear for each separate medical or surgical procedure received on that date.

If a machine listing is prepared in lieu of completing this form, all items must be furnished on the listing as is required on the form. The line for each service shown must be in the **same sequence** and in the **same detail**. Further, the listing must have the name of the plan, dates showing the period of time covered by the listing, column headings as shown on the form, and the certification statement and signature. The detailed instructions for completing the form are as follows:

Column 1—The HI claim number of the person receiving the listed service as shown on the HI identification card. Be sure to list the complete HI claim number including the prefix or suffix.

Column 2—Enter the name of the person receiving services, showing the last name first.

Column 3—Fill in the year at the top of the column labeled date of service. The month and day that the service or supply was furnished must be entered for each service. These dates should be entered numerically, e.g., August 10 would be entered 08–10.

Column 4—The place of service should be entered using the following letter codes:

- O—Doctor's Office
- C—Group Practice Clinic
- H—Patient's Home
- IH—Inpatient Hospital
- ECF—Extended Care Facility (nursing home)
- OH—Outpatient Hospital
- IL—Independent Laboratory
- OL—Other Location

Column 5—Enter in this column the appropriate code as specified in § 390C showing the specialty of the physician providing the service, or the type of service provided, or the type of supplier (other than the plan) from whom supplies or services were obtained. Enter the Physician Specialty Code for each service reported on the form that involved a "visit" to a physician.

The correct specialty code should be entered for **each** physician "visit" including "visits" to 2 or more physicians on the same day.

Enter the appropriate type of service code (for nonphysicians' services) as specified in § 390C for each service utilized that does **not** involve a "visit" to a physician—e.g., a blood sample taken by a laboratory technician, an x-ray plate taken by an x-ray technician, interpretation of a series of x-ray plates by a radiologist, etc.

Enter the appropriate type of supplier code as specified in § 390C for each instance where a plan member is referred to a medical supplier by the plan for medical supplies or equipment.

Column 6—Describe each surgical or medical procedure or treatment furnished to the beneficiary clearly, specifically, and in precise medical terms. Report each procedure on a separate line. Also describe in this column x-rays, laboratory tests, and similar procedures. Also describe here any prosthetic devices, braces, surgical dressings, and durable medical equipment provided the beneficiary. Describe all items verbally; do *not* enter codes.

Column 7—The illness or injury (diagnosis) for which the service or supply was furnished should be reported clearly and in precise medical terms. The exact description of the diagnosis should be reported; *do not* enter codes.

Instructions for Completing Group Practice Plan Individual Patient Utilization Report (Form SSA-1591)—Supplementary Medical Insurance Services

A form should be completed for each Part B beneficiary receiving services from the plan. Each form for a particular beneficiary should cover all covered services received during the reporting period. Attach an additional SSA-1591 form marked "continuation" if more room is required. The identifying information required in boxes 1 and 2 can be entered by use of an embossed card if the plan uses one. In itemizing services rendered, a separate line should be used for each date on which the beneficiary received services and separate lines should be utilized if multiple services were provided on the same date—one line for each service.

Box 1

Enter the beneficiary's name and health insurance claim number as shown on his (her) HI identification card. Be sure to list the *complete* HI claim number including the prefix or suffix.

Box 2

Show the name of your plan and the address of the office responsible for the beneficiary. Enter the 5-digit identification number assigned for use in the Social Security Health Insurance Program. This box also can be used by the GPPP to identify the particular part of the plan that furnished the services if this is necessary for record location in referral cases.

Item 3(a)—Date of Service

Fill in the year at the top of the column. If report overlaps 2 years, prepare separate reports. Enter month and day of service numerically, e.g., August 10 should be shown as 08/10.

Item 3(b)—Place of Service

Enter the place of each service using the following letter code:

- O—Doctor's Office
- C—Group Practice Clinic
- H—Patient's home
- IH—Inpatient hospital
- ECF—Extended care facility (nursing home)
- OH—Outpatient hospital
- IL—Independent laboratory
- OL—Other location

Item 3(c)—Physician Specialty, or Type of Supplier or Service

Enter in this column the appropriate code as specified in § 390C showing the specialty of the physician providing the service, or the type of service provided, or the type of supplier (other than the plan) from whom supplies or services were obtained. Enter the Physician Specialty Code for each service reported on the form that involved a "visit" to a physician.

The correct specialty code should be entered for *each* physician "visit" including "visits" to 2 or more physicians on the same day.

Enter the appropriate type of service code (for nonphysicians' services) as specified in § 390C for each service utilized that does not involve a "visit" to a physician—e.g., a blood sample taken by a laboratory technician, an x-ray plate taken by an x-ray technician, interpretation of a series of x-ray plates by a radiologist, etc.

Enter the appropriate type of supplier code as specified in § 390C above for each instance where a plan member is referred to a medical supplier by the plan for medical supplies or equipment.

Item 3(d)—Services Furnished

Describe the surgical or medical procedures or treatment furnished to the beneficiary clearly, specifically, and in precise medical terms. Report each procedure on a separate line. Also describe in this column x-rays, laboratory tests and similar procedures. Also describe here any prosthetic devices, braces, surgical dressings, and durable medical equipment provided the beneficiary. Describe all items narratively; do *not* enter codes.

Item 3(e)—Diagnosis

The illness or injury (diagnosis) for which the service or supply was furnished should be reported clearly and in precise medical terms. The exact description of the diagnosis should be reported; do *not* enter codes.

Box 4

Enter the dates covered by this report.

Box 5

Either the physician providing services or another plan official should sign and date the report.

**ADVISE OF TRANSMITTAL - MEDICAL INSURANCE
STATISTICAL SAMPLE****INTERMEDIARY IDENTIFICATION****DELIVER TO:**

Social Security Administration
Bureau of Data Processing and Accounts
Civic-Howard Building
211 West Lombard Street
Baltimore, Maryland 21201
Attn: Medical Insurance

1. ID
NUMBER
(5 DIGITS)

2. NAME AND ADDRESS

MEDICAL INSURANCE BILLS INCLUDED IN THIS TRANSMITTAL

3. BATCH NUMBER (3 DIGITS)

4. DATE BATCHED (SHIPPED)

5. TYPE OF BILLS (FORM NUMBER)

6. TOTAL NUMBER OF PAYMENT REQUESTS IN BATCH

SPECIALIZED BATCHES

☐ DELETIONS RETURNED
(ORIGINAL TRANSMITTALS ATTACHED)

BILLS DELETED FOR RETURN TO INTERMEDIARY

HI CLAIM NUMBER

ADDITIONAL INFORMATION REQUIRED
(See description of code listed below)

ADDITIONAL INFORMATIONAL OR MATERIAL NEEDED FOR CONTINUOUS SAMPLE CASE(S)**CODE**

- | | | |
|---|------------------------------------|---|
| 4. HI claim number | 6. Place(s) of service | 11. Related Form SSA-1490, 1554 or 1556 |
| 2. Full description of services furnished | 7. Physician's assignment decision | 12. Legible copy |
| 3. Physician's charges for each service | 8. Physician speciality code | 13. Original entries are obscured |
| 4. Reasonable charge determination for each service | 9. Physician identification number | 14. Provider No(s). (Form SSA-1554) |
| 5. Date(s) of service | 10. Diagnosis | 15. GPPP No. (Form SSA-1556) |

Resubmit corrected claims per Section 6615.2 of the Part B Intermediary Manual or GPPP Letter No. 48.

FORM SSA-1575 (1-69)

SOCIAL SECURITY ADMINISTRATION COPY

[illegible]

CHAPTER IV

CARRIER DEALING PLANS

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400. INTRODUCTION

This chapter sets forth policy and procedures governing GPPP reimbursement through area carriers on the basis of reasonable charges.

The area carrier has the responsibility for determining the reasonable charges for services of physicians practicing within its jurisdiction and to make payments on that basis. The carrier has similar responsibilities with respect to carrier dealing GPPP's in its service area.

Where the SSA has knowledge of a GPPP operating in a carrier's service area, the carrier has been provided whatever information was available on the plan.

Any question that a carrier dealing plan has with respect to its participation in the Medicare program should be referred to its carrier. The carrier will keep SSA advised of any problem areas by referrals to the BHI Regional Office.

402. REASONABLE CHARGES

The law does not contemplate the establishment of a general fee schedule applicable to all physicians or other suppliers of medical and other health services. In determining the reasonable charge for a covered service the carrier is required to take into account the existing practice with respect to charges as usually assessed by the individual physician as well as by others practicing in the locality.

Two basic criteria are provided within the law for determining reasonable charges for physician services. These are:

- (1) the customary charge for similar services generally made by the physician or other person furnishing such service, as well as
- (2) the prevailing charges in the locality for similar services.

In addition, the law specifies that where payment is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier. However, the reasonable charge cannot exceed the actual charge made by the physician or supplier for the service.

The carrier, through which reasonable charge reimbursement will be made to the GPPP, is responsible for the application of the above criteria in making reasonable charge determinations.

403. REASONABLE CHARGE FOR A PREPAID SERVICE

A distinguishing characteristic in furnishing physician services in the GPPP setting is that there are no fees or charges assessed for such services when fur-

nished to a plan member by a plan physician. The "fee-for-service" concept of medical practice is eliminated by the prepayment mechanism. As a result, there is no fixed or established 'customary charge' for a specific physician service or procedure when such service or procedure is furnished by a plan physician to a plan member. In effect, the customary charge for such a service or procedure is the actual expense the plan incurs in furnishing that service.

Consequently, a GPPP that will receive reimbursement on the basis of reasonable charges must compute its 'customary charge' on the basis of the actual expenses incurred in furnishing services.

405. PHYSICIAN COMPONENT OF GPPP CUSTOMARY CHARGE

Where the compensation of plan physicians is contractually fixed, e.g., salary or retainer, that fixed amount is the appropriate starting point for computing the customary charge for a service furnished a plan member by the plan physician.

The portion of the physicians' compensation that is attributable to rendering covered medical services to Part B beneficiaries who are plan members may be determined for each physician or on the basis of the total physician complement of the plan or the departmental complement of physicians. The plan must establish to the carrier's satisfaction that the physician compensation portion of the developed customary charge is reasonable and will result in a total monetary yield that approximates an amount equal, in the aggregate, to the total compensation of plan physicians.

406. OTHER COST ELEMENTS OF GPPP CUSTOMARY CHARGE

Costs incurred that are necessary, proper, and essential to furnishing medical care are appropriate factors for inclusion in computing a GPPP's customary charges. Both direct and indirect costs essential to the development, maintenance, and operation of patient care facilities and activities may be included. Elements of cost normally applied in setting individual premium rates or amounts to be paid for coverage of entire groups or classes of people and such costs as are common and accepted factors of the plans' activities are also allowable.

Expenses that are not related to patient care or amounts specifically excluded from reimbursement under Medicare will not be allowed. Thus, such costs as sales promotion, advertising, and other costs directed to the operation of the plan and the maintenance of enrollment records are not reimbursable.

408. ALLOWANCE FOR TIME SPENT IN RENDERING PHYSICIAN SERVICES

In recognition of the fact that as a group, persons age 65 and over require greater time per service than

those under age 65, a time factor of 20 percent will be allowed. This factor will be applicable only where the charge is related to the plan's costs by whatever method is used. It does not apply in the normal fee-for-service case where the fee is not customarily varied according to the duration of the visit.

Where the GPPP feels that this 20 percent time allowance is not applicable to its operations it may accumulate data for review and possible adjustment. Such data is to be submitted to the plan's carrier for approval before any change may be effected in the time factor. (The 20 percent time allowance is subject to adjustment as may be warranted by studies and data obtained by the Administration.)

410. PATIENT "VISIT" WITH PLAN PHYSICIAN

The term "visit" means a face-to-face contact between a plan member and a plan physician either on an appointment or nonappointment basis, for covered diagnostic examination and/or treatment. When a visit with one physician results in an appointment referral to another physician (on the same day or at a later date) the visit to the second physician is also counted as a visit. If, during the patient's initial visit, the physician asks other physicians to participate or consults with others, for whatever reason, the entire episode is counted as a single visit.

Interpretation of the results of diagnostic tests or procedures (laboratory, x-ray, EKG, etc.) where there is no face-to-face contact between the patient and physician does not constitute a visit. The physician's compensation for this service is to be included as an element of the plan's costs. When there is an actual need for a face-to-face contact with the physician by the patient because explanation and interpretation of test results are customarily provided in this manner, it may be counted as a visit. Services by means of telephone calls between physician and patient (including those in which the physician provides advice and instructions to or on behalf of a patient) are not covered Medicare services and do not constitute visits.

412. REIMBURSEMENT OF REASONABLE CHARGES

The methods suggested below may be used in computing customary charges. Plans may utilize whichever method is best suited to their record-keeping systems

or they may suggest alternative methods for review by the carrier. Plans may not change from one method to another during an accounting period without permission, in writing, from the carrier. A GPPP may start with one method while developing the data necessary to use another method. (These methods apply only where the physician who renders the services is on an other than fee-for-service basis.)

A. Statistical Visit Method.—The average charge for a visit may be determined by dividing the estimated medical care costs of the plan by the estimated total number of visits to the plan, adjusted to reflect the additional time required to treat patients age 65 and over. The result then becomes the average charge to be applied to all covered services rendered by the plan to Medicare beneficiary plan members.

In applying this method the plan could (1) figure the average charge per visit excluding the costs of noncovered services and the number of visits for such services, or (2) figure such charge without excluding the costs for services not covered under Medicare and the number of such services. Where the plan has adequate records to allow it to do so, it should exclude the costs of noncovered services and the visits for such services.

A refinement of the determination of charges on an overall average would be to determine average charges by departments. This approach would result in the determination of charges that more accurately reflect the complexity of the services received by the individual. For this reason, the plan should, whenever possible, determine charges on a departmental basis. (Where a plan provides outpatient psychiatric services the 'charge' for such service must be determined as a separate computation for that department alone. See § 416.)

EXAMPLE:

Costs for providing medical care services to all enrollees (Medicare beneficiary and non-beneficiary) in the previous year totalled \$875,000. During that year there were 95,000 visits, of which 9,500 (10%) were by persons age 65 and older. The GPPP estimates that 1966 costs will total \$900,000 and there will be a total of 100,000 visits with 10% of the visits made by those age 65 and older. The statistical visit charge is computed as follows:

Estimated number of visits by plan members and non-plan members	
age 65 and older -----	10,000
Adjusted for time factor (10,000 x 1.2) -----	12,000
Estimated number of visits by others -----	90,000
Total number of visits (adjusted for time factor) -----	102,000
Total estimated costs (\$900,000)	
<hr/>	
Total estimated visits (102,000)	
<hr/>	
Adjusted charge per visit age 65 and older	\$8.82 (charge per statistical visit)
	\$10.58 (\$8.82 x 1.2)

A refinement of this method can be made by excluding the costs of such departments as pediatrics, obstetrics, dentistry, etc., which would either not be used by persons age 65 and over or not be covered under Medicare, and also excluding from total visits

the visits to these departments. Thus, if \$300,000 of the total costs were attributable to such excluded departments and the number of visits to these departments totalled 45,000 (of which 1,000 were by persons age 65 and over) the computation would be:

Estimated number of visits by plan members and non-plan members	
age 65 plus (10,000-1,000) -----	9,000
Adjusted for time factor (9,000 x 1.2) -----	10,800
Estimated number of visits by other persons (90,000-44,000) -----	46,000
Total number of visits (adjusted for time factor) -----	56,800
Estimated costs (\$900,000-\$300,000) \$600,000	
Total visits 56,800	= \$10.56
Adjusted charge per visit (\$10.56 x 1.2)	\$12.67

A further refinement can be made if the plan's accounting and utilization records are set up on a depart-

ment basis as follows:

Department	Costs	Visits by Under 65	Visits by Over 65	Age 65 Visits Adjusted by 1.2	Total Visits	Charge per Visit	Age 65 Charge Adjusted by 1.2
Pediatrics	\$175,000	27,500	—	—	27,500	\$ 6.36	N/A
General Medicine	225,000	33,900	6,100	7,320	41,220	5.46	\$ 6.55
Internal Medicine	75,000	5,500	2,000	2,400	7,900	9.49	11.39
OB-GYN	150,000	12,000	500	600	12,600	11.90	14.28
Surgery	175,000	800	200	240	1,040	168.27	201.92
Eye	50,000	4,900	600	720	5,620	9.90	11.80
Ear-Nose- Throat	50,000	5,400	600	720	6,120	8.17	9.80

B. *Schedule of Predetermined Charges.*—It may be possible for a GPPP to develop a 'schedule of charges' for various types of services which would be related to the plan's costs of providing medical care.

To develop this schedule of charges, the plan would consider the compensation it pays its physicians to render services and the number of various types of services it is estimated that the doctors would render during the year. The schedule would then be developed by setting a charge for each type of service rendered which, when multiplied by the number of each type of service rendered, would yield an amount equal to the physician's yearly compensation. To this amount the GPPP may add a proportionate amount for those administrative and other indirect costs which are related to rendering medical care. This would then become the charge for the particular type of service. If it wishes, the plan could determine such a schedule for each physician.

One way of arriving at this schedule of charges would be through the use of a relative value scale which is in common use by a State or local medical society. To accomplish this, the plan would utilize the records of the latest year for which it has complete records. Relative value points would be assigned for each service rendered by the plan during the year. The total of these relative value points would then be divided into the estimated total costs of the plan for providing medical care for the current year. The result of this computation would be a monetary conversion factor which could be applied to relative value points for services in the current year to arrive at a charge for each service.

EXAMPLE:

The GPPP reviews its records and assigns relative value points for each visit as follows:

<i>Procedure</i>	<i>RV Points for under 65 (number of visits x the RV points)</i>	<i>Adjusted RV Points for Age 65 Plus (number of visits x RV points x 1.2)</i>	<i>Total Relative Value Points</i>
Initial office visit (routine)	900 x 2 = 1,800	100 x 2.4 = 240	2,040
Follow-up office visit (routine)	18,000 x 1 = 18,000	2,000 x 1.2 = 2,400	20,400
Electrocardiogram with interpretation and report	600 x 3 = 1,800	150 x 3.6 = 540	2,340
Gastrotomy with exploration or foreign body removed	9 x 50 = 450	1 x 60 = 60	510

Relative value points would be determined for each of the various services or procedures. The total number of points (as per the last column in the above example) would be added and for this example we will assume the total amount of RV points is 225,000. This figure is divided into the total cost of \$900,000, yielding a conversion factor of \$4.00. This is then multiplied by 1.2 to accommodate the time allowance factor, resulting in a conversion factor of \$4.80 for covered services rendered to plan members who are Medicare beneficiaries. (A service for which the RV point value is 2.0 would warrant a charge of \$9.60; 10 points—\$48.00; 15 points—\$72.00; etc.).

C. Reasonable Charges as Related to Premiums.—Many GPPP's that will be reimbursed on the basis of reasonable charges have a definite premium amount payable by all members on a periodic basis. In determining the amount of this premium the plan usually estimates the amount of money it must collect from each enrollee to cover the costs of rendering all medical services. To these costs is added a percentage which the plan requires for expansion, contingencies, etc. Where the plan has a fixed percentage which it adds to its costs to establish the premium, it may use that percentage in determining its charges. This percentage is subject to a determination, by the carrier, as to its reasonableness before it will be allowed as an appropriate cost element of the ultimate reasonable charge.

Relating the reasonable charge to the premium would be accomplished as follows:

If the plan has a cost system and is capable of determining the cost of each service, including the time factor, the plan may add to its cost that percentage which it normally adds to its estimated costs in setting the amount of its premiums. To determine this percentage, the plan will have to show how it arrives at the premium it charges. The percentage of cost that it adds in determining the total premium would be applied to the costs of the individual service in determining the reasonable charge. For example: the plan, in setting the amount of its premium, adds 5% above its estimated costs. A beneficiary enrollee of the plan receives a medical service

which costs the plan \$3.00 to render. The charge for such service will be \$3.15 (\$3.00 plus 5%).

NOTE: Where a GPPP uses the statistical visit method outlined in A. above, it is obvious that a valid comparison cannot be made with the prevailing rate in the locality for a particular service by physicians in the private practice of medicine. The carrier must determine that the average charges are actually related to the plan's cost of providing medical services. The carrier may desire to review the plan's actual cost records that formed the basis for the average charge computation. It may, on the other hand, be satisfied with an audited cost statement or a statement prepared by a plan representative. Since a carrier is required, by the terms of its contract with the SSA, to determine the reasonableness of charges, it is the carrier's responsibility to require adequate documentation assuring that the plan's average charges are related to the costs. In addition, the carrier must determine that the average charge is 'reasonable' taking into consideration the range of services made available by the plan. Thus, it may be necessary to compare the charges for one plan to the charges for another GPPP, whose health care services lend themselves to such comparison, i.e., there is similarity in size, scope of services, cost of operation, etc.

Where the GPPP develops a schedule of charges or applies a conversion factor to relative value points, thus placing a charge on each service in relation to the complexity of that service, the carrier must compare such charge to the prevailing rate in the locality and pay no more than the amount it would otherwise determine to be the 'reasonable charge' for that service.

414. REASONABLE CHARGE REIMBURSEMENT OF GPPP'S ON A NON-BILL BASIS

Another method of reimbursement on the basis of reasonable charges related to cost may be used as detailed in § 303.

416. OUTPATIENT PSYCHIATRIC SERVICES

Because of the limitation specified in Section 1833(c) of the Act (§ 255ff.), carrier dealing plans furnishing outpatient psychiatric services to their

members are required to determine an average charge per psychiatric visit based upon the physician cost of providing these services. It will also be necessary for such plans to redetermine the charge per visit being reported for their other care services to exclude the physician costs associated with furnishing outpatient psychiatric services because the physicians' component of such services will be reimbursed separately. Costs, other than physicians' salaries, connected with the rendering of such care will be included in the plan's other care costs subject to reimbursement. This requirement became effective April 1, 1968.

All plans are encouraged to continue with the method they are now using to determine a charge per visit since all the approved methods lend themselves to determining a charge for psychiatric visits. Regardless of the method used to determine a charge per psychiatric visit, the plan will be required to:

1. Determine the cost of providing outpatient psychiatric visits to all members from April 1, 1968, through December 31, 1968.

2. Determine the total number of outpatient psychiatric visits rendered all plan members between April 1, 1968, and December 31, 1968.

3. Determine the total number of outpatient psychiatric visits rendered enrolled beneficiaries during the same period.

Fee-for-service payments made to psychiatrists on an "arranged-for" basis should not be included in the plan's cost of providing outpatient psychiatric services. Plans should submit receipted bills for such services to the area carrier with a form SSA-1490. Once the plan has developed the above data it may then apply the estimates to the Statistical Visit Method or any other approved method to determine a charge per psychiatric visit.

To calculate the estimated average cost per visit, see § 324 A.

After receiving the carrier's approval of the charge determined for these visits the plan should begin reporting the adjusted charge per outpatient psychiatric visit for all such visits rendered enrolled beneficiaries after March 31, 1968.

In addition to the above computation, it will also be necessary for the plan to revise the charge per visit it is currently reporting for its other covered services since the physician costs attributable to outpatient psychiatric visits will be reimbursed separately. To accomplish this plan would determine the following items:

1. The number of visits for all members from April 1, 1968, through December 31, 1968, not including visits applicable to outpatient psychiatric services.

2. The number of visits for plan members age 65 and over for the period April 1, 1968, through

December 31, 1968, not including visits applicable to outpatient psychiatric services.

3. The costs applicable to medical care for the period April 1, 1968, through December 31, 1968, less those costs applicable to outpatient psychiatric visits for the same period.

When the above estimates are completed, the plan should then apply these revised figures to the method it has chosen for determining a charge per visit and inform the carrier of the new charge as well as the calculations used to determine that amount.

418. REIMBURSEMENT FOR GPPP SERVICES TO NON-MEMBERS

A GPPP whose facilities and physician services are available to non-members and which customarily furnishes such services on a fee basis will be reimbursed for them on a "reasonable charge" basis, even though the GPPP has elected to be reimbursed on the basis of reasonable costs for its member services. (The option to elect 'reasonable cost' reimbursement applies only to the services provided plan members who prepay for services.)

Reimbursement for non-member services furnished on a fee basis will be made through the area carrier in all cases and be subject to a 'reasonable charge' determination by the carrier. The plan may bill the patient directly or accept assignment in these instances. The plan may bill its customary charge for rendering such services even though the charge for a service to plan members is computed by one of the methods outlined in § 412.

419. REIMBURSEMENT FOR "ARRANGED-FOR" SERVICES

GPPP's sometimes find it necessary to purchase physician services on a fee-for-service basis. This may occur because needed specialist services cannot be furnished by the plans' salaried physicians, or a physician service is required by a member when he is outside the plan's service area. Reimbursement for such services may be made to the GPPP where the services are furnished under an "arrangement," which is described as follows:

An *arrangement* is an agreement (either written or oral) made with a physician outside the plan, which is expected to be an on-going arrangement, entered into at a time when neither the physician nor the plan was aware that his services were required to treat a specific individual. (A telephone call by the plan or the physician made at the time an individual requires medical services because of illness or injury will not meet this requirement.) The agreement must provide that the physician will treat members of the plan and spell out the basis for the

amount of the plan's payment for such services, e.g., fee schedule, customary charge, customary charge less specified percentage, etc. (NOTE: In the case of certain hospital-based physicians, the hospital may negotiate such an arrangement. See § 310.1.) Where laboratory or x-ray services are purchased from a certified independent laboratory or approved portable x-ray service, or are provided by a physician in his private office, such services will be deemed to be furnished under an "arrangement."

Where a plan member is referred to one of these physicians for a covered medical service, the plan may pay the physician's fee for such service and seek reimbursement from the area carrier. The plan will submit the receipted bill and a form SSA-1490, in the name of the plan, showing the name and account number of the plan member-Medicare beneficiary, to the carrier servicing the physician. The carrier will determine the individual's deductible status and the 'reasonable charge' for such service and make the appropriate reimbursement to the plan.

420. REIMBURSEMENT OF PART B SERVICES RECEIVED OUTSIDE THE PLAN—NOT ARRANGED FOR BY THE PLAN

A. Reimbursement for Services, including out-of-area services, furnished by a supplier or by a physician who does not have an arrangement with the plan must be billed through the carrier servicing the area where the medical treatment was provided. Where services are rendered by a "provider of services," i.e., hospital, extended care facility, or home health agency, reimbursement must be made to the provider. Items (B) through (D) below discuss the various ways reimbursement for nonarranged services may be secured.

B. Where an assignment has been made by the individual and accepted by the treating physician, the latter may bill his area carrier. The individual remains responsible for the deductible and coinsurance (20 percent of the reasonable charge) which the plan may wish to pay.

C. The individual may obtain an itemized bill from the treating physician and submit it to the appropriate carrier. In this instance, the carrier will make any required reimbursement to the individual. The individual would receive from the carrier a statement of the amount paid by the SSA. The plan may use this statement as a basis for reimbursing the enrollee for any amount not paid by the SSA. Under this method, the beneficiary would be responsible for paying the treating physician.

D. Under certain conditions, GPPP's may be paid Part B benefits directly for services furnished members outside the plan, e.g., emergency physician services furnished to a member which are not provided by a

plan physician nor by physicians with whom the plan has arrangements. To do so, a plan must meet the following requirements:

1. It must have available in its files the enrollee's authorization to pay the plan Part B benefits due on the basis of bills which the plan has paid in full on his behalf. (If the enrollee is unable to execute such authorization, it may be signed on his behalf by his legal representative if he has one, or his representative payee, a close relative, or other person managing the enrollee's affairs.) See § 425 C for suggested language of the assignment form.

2. The plan must request payment on an SSA-1490 or SSA-1490U. (See § 499, Exhibits 1 and 2.)

The plan completes Part I of the form, which need not be signed by the enrollee. The plan should furnish sufficient itemization of the services it has paid for (with dates of services, places of services, and charges) to enable a reasonable charge determination to be made. This may be done by submitting Part II of the SSA-1490 or 1490U signed by the physician or an itemization on the physician's bill form.

3. Where the SSA 1490 rather than the SSA-1490U is used, a statement on the plan's letterhead should be attached to each request for payment above the signature of a responsible officer or employee of the plan, substantially as follows:

I request payment of Part B benefits on behalf of (name of plan), hereafter referred to as "the organization," in accordance with approval # ----- I certify in connection with this request that the enrollee named above has been furnished the services described in this claim, and that:

(a) the organization has paid in full the amount of the charges for the services shown on this claim;

(b) the organization has the enrollee's written authorization to receive Part B benefits due on the basis of bills paid in full by the organization;

(c) the organization relieves the enrollee of liability for the services specified in this claim, and will not seek any reimbursement from him with respect to such services, if a Part B benefit is paid to the organization on this claim.

/s/

Title

The enrollee's name and HI number, and the current date should be entered above the statement.

4. The statement in 3, above on either a separate attachment, or on the SSA-1490U form, will constitute

sufficient proof that the bill has been paid in full, in absence of any indication to the contrary. Where it is found that a plan has breached the terms of the certification made in its statement (e.g., has failed to pay the physician, or claimed payment from the enrollee for services on which it has received Part B payment), corrective action will be necessary including, where appropriate, terminating the arrangement to pay Part B benefits to the plan.

5. The plan must accept the burden of paying any applicable deductible, the coinsurance amount, and any amount it may have to pay in excess of the reasonable charge as determined by the carrier. The GPPP is not bound to pay every bill of a plan member; it may choose to pay only bills for specified services and may limit the amount it will pay. However, the Part B benefits due will be paid only if the GPPP pays the full amount of the bill for which it is claiming reimbursement. (When such payment is made to the GPPP, an explanation of benefits will be sent not only to the plan, but to the patient, in such terms that there will be no doubt as to the source, amount, and service on which the payment is based.)

6. It should be clearly understood that the SSA does not guarantee payment of Part B benefits on all bills of aged members and that it cannot undertake to inform the plan which of its members are enrollees, or check lists of members to identify those who are enrollees, or guarantee continuation of enrollment (since Part B coverage may be terminated voluntarily or for failure to pay premiums).

If a plan desires to use the procedure described above, it should advise the area carrier to this effect and indicate it is willing to comply with the above-mentioned conditions. The carrier will notify the SSA, which will assign a number to the plan (for use on Part B claims) and notify all other carriers. Immediately upon receiving the number, the carrier will notify the plan of approval and of the time needed before Part B claims can be submitted under this procedure.

425. BILLING BY CARRIER-DEALING GPPP's

A. Carrier dealing plans claim reimbursement on Form SSA-1556, Prepayment Plan For Group Medical Practices Dealing Through a Carrier (§ 499, Exhibit 1), when they will be paid on the basis of reasonable charges related to costs of furnishing services to their subscribers.

B. When plans qualify to receive benefits for services for which they cannot be paid Part B benefits as suppliers (see § 420), forms SSA-1490, Request for

Medicare Payment (§ 499, Exhibit 2), and SSA-1490U, Request for Medicare Payment by Qualified Organizations (§ 499, Exhibit 3), are used. When the SSA-1490 is used, item 6 should be left blank and the plan should attach a statement on its letterhead which includes all the information in item 5 of the SSA-1490U as well as the plan representative's signature and title.

Instructions for completion of forms SSA-1556, 1490 and 1490U are included on the back of the forms.

C. *Assignment.*—Subscribers of the plan who are Medicare enrollees and receive covered medical services from physicians of the plan, may assign payment to the plan.

The assignment on the form serves to advise the carrier that the plan has an assignment on file and in effect from beneficiaries for whom payment is being requested. In addition, the plan agrees that under the terms of the assignment, the reasonable charge for any service as determined by the carrier shall be the full charge for the service. To make such assignment to the plan, and to avoid the necessity of doing so each time services are furnished, the beneficiary may execute a blanket assignment form. This assignment will be in effect as long as the beneficiary remains a plan member, or until he revokes it in writing. The following is the suggested language of the assignment form:

Assignment

I assign payment under the Supplementary Medical Insurance Program (Part B of Title XVIII) to the (Name of Plan) of Supplementary Medical Insurance Benefits payable on my account by reason of medical services furnished me or paid for by that organization.

This assignment will continue as long as I remain a member of the aforementioned organization, or until canceled in writing by me.

(HI Number)	(Signature)
(Address)	(Date)

499. EXHIBITS

1. Prepayment Plan for Group Medical Practices Dealing Through a Carrier SSA-1556.
2. Request for Medicare Payment (SSA-1490).
3. Request for Payment by Qualified Organizations (SSA-1490U).

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

AND WELFARE PREPAYMENT PLAN FOR
GROUP MEDICAL PRACTICES DEALING THROUGH A CARRIER
MEDICAL INSURANCE BENEFITS - SOCIAL SECURITY ACT

Form Approved,
Budget Bureau No. 72-R773

NAME AND ADDRESS OF GROUP PRACTICE PREPAYMENT PLAN	COPY FROM HEALTH INSURANCE CARD	NAME OF BENEFICIARY (Patient)	DATE OF BIRTH
		ADDRESS (Street address, City, State, ZIP Code)	
C.P.F. NO.		CLAIM NUMBER	

[illegible]

3. ARE ANY SERVICES, ILLNESSES OR INJURIES DESCRIBED IN ITEM 1 EMPLOYMENT RELATED? ☐ Yes ☐ No (If "yes," indicate which one(s) and give name and address of employer below.)

2.	TOTALS
----	--------

⁴ Deductible and coinsurance paid

5. Any unpaid balance

The above named organization has in file and currently in effect an assignment by this patient of amounts payable under Part B of Title XVIII of the Social Security Act for medical services furnished him by it or under arrangements made by it. The organization hereby accepts such assignment with the understanding that under its terms the reasonable charge for any service as determined by the carrier shall be the full charge for the service.

6. SIGNATURE OF AUTHORIZED REPRESENTATIVE OF GROUP PRACTICE PREPAYMENT PLAN 7. DATE

¹ See reverse for listing of codes to be used in this block.

²0-Doctor's Office

C-Clinic

IH-Inpatient Hospital

ECF-Extended Care Facility

IL-Independent Laboratory (give name & address in 1D)

H-Patient's Home

OH-Outpatient Hospital

NH—Nursing Home

OL-Other Locations (Specify in ID)

Instructions for Completing Report of Services

1A—Date of Each Visit or Service.—Enter the date for each service including both services which involved a *visit*, i.e., a face to face contact with a physician, and the services which did not involve a *visit*. (See the "Guidelines for Reimbursement of Group Practice Prepayment Plans" for a full definition of a *visit*.)

1B—Place of Service.—Enter the appropriate letter code from the footnote on the form.

1C—Physician Specialty or Supplier Code.—Show the appropriate code from the list below.

1D—Describe in specific medical terms all surgical or medical procedures and treatment furnished to the beneficiary.

1E—Diagnosis.—Furnish the professional description of the diagnosis.

1F—Enter charges only for the line items which represent services involving a *visit*. (See 1A instruction above.)

Physician Specialty Code	Physician Specialization
01	General Practice
02	General Surgery
03	Allergy
04	Otology, Laryngology, Rhinology
05	Anesthesiology
06	Cardiovascular Disease
07	Dermatology
08	Family Practice
09	Gynecology (Osteopaths only)
10	Gastroenterology
11	Internal Medicine
12	Manipulative Therapy (Osteopaths only)
13	Neurology
14	Neurological Surgery
15	Obstetrics (Osteopaths only)
16	OB — Gynecology
17	Ophthalmology, Otology, Laryngology, Rhinology (Osteopaths only)
18	Ophthalmology
19	Oral Surgery (Dentists only)

Physician Specialty Code	Physician Specialization
20	Orthopedic Surgery
21	Pathologic Anatomy; Clinical Pathology (Osteopaths only)
22	Pathology
23	Peripheral Vascular Diseases or Surgery (Osteopaths only)
24	Plastic Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Psychiatry, Neurology (Osteopaths only)
28	Proctology
29	Pulmonary Diseases
30	Radiology
31	Roentgenology, Radiology (Osteopaths only)
32	Radiation Therapy (Osteopaths only)
33	Thoracic Surgery
34	Urology
49	Miscellaneous
99	Unknown
NA	To be used only until January 1, 1967

Identify the type of supplier involved using the following 2-digit codes—

Code	Type of Supplier
51	Medical supply company with C.O. (Certified orthotist-certified by American Board For Certification in Prosthetics and Orthotics) certification
52	Medical supply company with C.P. (Certified prosthetist-certified by American Board for Certification in Prosthetics and Orthotics) certification
53	Medical supply company with C.P.O. (Certified prosthetist-orthotist-certified by American Board for Certification in Prosthetics and Orthotics) certification
54	Medical supply company not included in 51, 52 or 53
55	Individual CO
56	Individual CP
57	Individual CPO
58	Individual not included in 55, 56, or 57
59	Ambulance service supplier, e.g., private ambulance companies, funeral homes, etc.

Code	Type of Supplier
60	Public Health or Welfare Agencies (Federal, State, Local)
61	Voluntary Health or Charitable Agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities, Inc., etc.)
69	All other, e.g., Drug and Department Stores (trusses)
*71	Diagnostic X-ray
*72	Diagnostic laboratory
*73	Physiotherapy
*74	Occupational Therapy
*75	Other medical care
88	Unknown
NA	To be used only until January 1, 1967
(Not Available)	

*Use these codes only when the specified services did not involve a "visit" to a physician.

REQUEST FOR MEDICARE PAYMENT

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

(See Instructions on Back—Type or Print Information)

Form Approved
Budget Bureau No.
72-RO730

PART I—PATIENT TO FILL IN ITEMS 1 THROUGH 6 ONLY

A	Copy from your HEALTH INSURANCE CARD (See example on back)	<div style="border: 1px solid black; padding: 5px;"> 1 Name of patient </div> <div style="border: 1px solid black; padding: 5px;"> 2 Health insurance claim number <div style="display: flex; justify-content: space-between;"> Letter <input type="checkbox"/> Male <input type="checkbox"/> Female </div> </div>
3 Patient's mailing address	City, State, ZIP code	Telephone Number
4 Describe the illness or injury for which you received treatment (Always fill in this item if your doctor does not complete Part II below)		Was your illness or injury connected with your employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
5 If you have other health insurance or if your State medical assistance agency will pay part of your medical expenses and you want information about this claim released to the insurance company or State agency upon its request, give the following information.		
Insuring organization or State agency name and address		Policy or Medical Assistance Number
6 I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.		
Signature of patient (See instructions on reverse where patient is unable to sign)		Date signed

**SIGN
HERE** ➔

PART II—PHYSICIAN OR SUPPLIER TO FILL IN 7 THROUGH 14

7	A. Date of each service	B. Place of service (*See Codes below)	C. Fully describe surgical or medical procedures and other services or supplies furnished for each date given	D. Nature of illness or injury requiring services or supplies	E. Charges (if related to unusual circumstances explain in 7C)	Leave Blank
					\$	
8 Name and address of physician or supplier (Number and street, city, State, ZIP code)				Telephone No.	9 Total charges \$	
				Physician or supplier code	10 Amount paid \$	
					11 Any unpaid balance due \$	
12 Assignment of patient's bill (See reverse) <input type="checkbox"/> I accept assignment <input type="checkbox"/> I do not accept assignment				13 Show name and address of facility where services were performed (If other than home or office visits)		
14 Signature of physician or supplier (A physician's signature certifies that physician's services were personally rendered by him or under his personal direction)				<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DDS Other degree _____	Date signed	

*O—Doctor's Office
IL—Independent Laboratory

H—Patient's Home (If portable X-ray services, identify the supplier)
IH—Inpatient Hospital

ECF—Extended Care Facility
OH—Outpatient Hospital*

OL—Other Locations
NH—Nursing Home

FORM SSA-1490 (1-77)

Department of Health, Education, and Welfare
Social Security Administration

HOW TO FILL OUT YOUR MEDICARE FORM

There are two ways that Medicare can help pay your doctor bills

One way is for Medicare to pay your doctor.—If you and your doctor agree, Medicare will pay him directly. This is the assignment method. You do not submit any claim; the doctor does. All you do is fill out Part I of this form and leave it with your doctor. Under this method the doctor agrees to accept the charge determination of the Medicare carrier as the full charge; you are responsible for the deductible and coinsurance. Please read Your Medicare Handbook to help you understand about the deductible and coinsurance. (Because Medicare has special payment arrangements with group practice prepayment plans, these plans handle all claims for covered services they furnish to their members.)

The other way is for Medicare to pay you.—Medicare can also pay you directly—before or after you have paid your doctor. If

you submit the claim yourself, fill out Part I and ask your doctor to fill out Part II. If you have an itemized bill from him, you may submit it rather than have him complete Part II. (This form, with Part I completed by you, may be used to send in several itemized bills from different doctors and suppliers.) Bills should show who furnished the services, the patient's name and number, dates of services, where the services were furnished, a description of the services, and charges for each separate service. It is helpful if the diagnosis is also shown. Then mail itemized bills and this form to the address shown in the upper left-hand corner, Block A. If no address is shown there, use the address listed in Your Medicare Handbook—or get advice from your nearest social security district office.

SOME THINGS TO NOTE IN FILLING OUT PART I
(Your doctor will fill out Part II).

- 1 & 2** Copy the name and number and indicate your sex exactly as shown on your health insurance card. Include the letters at the end of the number.
- 3** Enter your mailing address and telephone number, if any.
- 4** Describe your illness or injury. Be sure to check one of the two boxes.
- 5** If you have other health insurance or expect a welfare agency to pay part of the expenses, complete item 5.
- 6** Be sure to sign your name. If you cannot write your name, sign by mark (X), and have a witness sign his name and enter his address on this line.

If the claim is filed for the patient by another person he should enter the patient's name and write "By", sign his own name and address in this space, show his relationship to the patient, and why the patient cannot sign. (If the patient has died the survivor should contact the nearest social security office for information on what to do.)

IMPORTANT NOTE.—This form may also be used by a supplier, or by you to claim reimbursement for charges by a supplier for services such as the use of an ambulance or medical appliances.

If the physician or supplier does not want Part II information released to the organization named in item 5, he should write "No further release" in item 7C following the description of services.

Health Insurance

SOCIAL SECURITY ACT

NAME OF BENEFICIARY
JOHN Q PUBLIC

CLAIM NUMBER
000-00-0000-A

IS ENTITLED TO
HOSPITAL INSURANCE
MEDICAL INSURANCE

SEX
MALE

EFFECTIVE DATE
7-1-66
7-1-66

SIGN HERE
John Q. Public

REQUEST FOR MEDICAL ASSISTANCE PAYMENT MEDICAL INSURANCE BENEFIT - SOCIAL SECURITY ACT <small>(See instructions on Back - Type A and Information)</small>						<small>Form Approved</small> 7-70-1 Use only No.	
A Patient's street address _____ 3 City, State, ZIP code _____		Copy from your HEALTH INSURANCE CARD (See example on back) _____ 2 Health insurance claim number _____ <input type="checkbox"/> Male <input type="checkbox"/> Female		4 Telephone Number _____ 5 Was your illness or injury connected with your employment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
6 If you have other health insurance or if your State medical assistance agency will pay part of your medical expenses and you want information about this claim released to the insurance company or State agency upon its request, give the following information: Insurance organization or State agency name and address _____ Policy or Medical Assistance Number _____							
7 I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original note, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below. Signature of patient: (See instructions on reverse where patient is unable to sign) _____ Date signed _____							
DECLARATION							
8 Name and address of physician or supplier (Number and street, city, State, ZIP code) _____		9 Total charges _____ 10 Amount paid _____ 11 Any unpaid balance due _____		12 List of items covered by insurance _____			
13 Assignment of patient's bill <input type="checkbox"/> I accept assignment <input type="checkbox"/> I do not accept assignment		14 Show name and address of facility where services were performed (if other than home or office visits) _____					
15 Signature of physician or supplier (Physician's signature certifies that physician's services were personally rendered by him or under his personal direction) _____ Other designee _____		<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DDS Date signed _____					
<small>See Back for Instructions</small>		<small>See Back for Instructions</small>					

**REQUEST FOR MEDICARE PAYMENT
BY QUALIFIED ORGANIZATIONS
MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT**

Form approved
Budget Bureau No. 72-R0782

	1. Name of patient	
		<input type="checkbox"/> Male <input type="checkbox"/> Female
	2. Claim Number (Copy from his Medicare Card)	Telephone Number
	3. Street Address, City, State, Zip Code	

PART I — CLAIMS INFORMATION

4. Describe the illness or injury for which the patient received treatment (Always fill in this item if the doctor does not complete Part II below)	Was patient's illness or injury connected with his employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	--

5. "I request payment of SMI benefits on behalf of (Name and Address of Organization) _____

hereinafter referred to as "the organization," in accordance with approval # _____. I certify in connection with this request that the patient named above has been furnished the services described in this claim, and that:

- a. the organization has paid in full the amount of the charges for the services shown in this claim;
- b. the organization has the patient's written authorization to receive SMI benefits due on the basis of bills paid in full by the organization;
- c. the organization relieves the patient of liability for payment of the services specified in this claim, and will not seek any reimbursement from him with respect to such services, if an SMI benefit is paid to the organization on this claim.

6. Signature of Organization Representative	Title	Date
---	-------	------

PART II—PHYSICIAN OR SUPPLIER TO FILL IN 7 THROUGH 14

7. A. Date of each service	B. Place of service (*See Codes below)	C. Fully describe surgical or medical procedures and other services or supplies furnished for each date given	D. Nature of illness or injury requiring services or supplies	E. Charges (If related to unusual circumstances explain in 7C)	Leave Blank
				\$	

8. Name and address of physician or supplier (Number and street, city, State, ZIP code)	Telephone No.	9. Total charges	\$
	Physician or supplier code	10. Amount paid	\$
		11. Any unpaid balance due	\$
12. Show name and address of facility where services were performed (If other than home or office visits)			

13. Signature of physician or supplier (A physician's signature certifies that physician's services were personally rendered by him or under his personal direction)	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DDS Other degree _____	Date signed
--	--	-------------

* O—Doctor's Office

H—Patient's Home (If portable X-ray services, identify the supplier)

ECF—Extended Care Facility

OL—Other Locations

IL—Independent Laboratory

IH—Inpatient Hospital

OH—Outpatient Hospital

NH—Nursing Home

FORM SSA-1490U (3-66)

Department of Health, Education, and Welfare
Social Security Administration

INSTRUCTIONS—PLEASE READ BEFORE COMPLETING THE OTHER SIDE OF THIS FORM

Instructions To The Organization

An authorized representative of the organization should enter the patient's name, health insurance claim number, address, and sex in the appropriate blocks. He should complete item 1 in all cases if Part II is not completed and check the appropriate box. He should enter the organization's name and assigned number in the spaces provided in item 5 and sign the form in item 6 including his title and the date.

The form serves as a paid bill when the physician completes Part II.

If itemized bills are attached, THEY MUST SHOW:

- Name of person or organization furnishing the medical services or supplies. If they were not furnished by a physician, the name of the physician who prescribed the services or supplies should be shown.
- Name of patient receiving services or supplies.
- Each date services or supplies were provided.
- Place services were provided (home, office, hospital, etc.), and name of facility where service was rendered if other than home or office visits.
- A description of the services or supplies provided on each occasion. If the bill is for ambulance service, it should show the origin and destination.
- The charges for each medical service or item.
- To help speed handling of claims, the claim number should be written on each bill.

(It is helpful if the diagnosis is also shown.)

NOTE: No payment may be made to the patient or any other party for any charges which are imposed by an immediate relative of the patient (i.e., his spouse, parent, child, brother, or by a member of his household).

MAILING INSTRUCTIONS

Mail this form to the carrier handling medical insurance benefits in the area where the medical services or items were furnished. The nearest social security district office will be glad to help anyone who calls, writes, or telephones for assistance in filing his claim. If it is more convenient, you may get help from the carrier designated to handle medical insurance benefits for your area.

FOR MORE INFORMATION

If you have a question about the way a particular claim was handled, you should get in touch with the carrier which made the payment or with the nearest social security district office.

INSTRUCTIONS TO PHYSICIAN OR SUPPLIER FOR COMPLETING PART II

PHYSICIAN OR SUPPLIER—For each date in Item 7, the physician or supplier should indicate the place of service (see footnote on front), and show in item 12 the name of the place where the services were rendered if they were rendered at a place other than a physician's office or the patient's home. The physician or supplier should describe any medical or surgical procedure, attaching a supplementary statement if necessary, and should describe the illness or injury being treated. If more than one procedure or treatment was provided on a single date, describe each procedure separately. Include any charges for preoperative and postoperative care in surgical charges. The physician's or supplier's name and address should be entered in item 8. Complete items 9–11 to show amounts paid and balance due.

SUPPLIER—If the services or supplies were not furnished by a physician, the supplier should show in Item 7D the name of the physician prescribing them. A report for ambulance service should show the origin and destination in Item 7C.

PHYSICIAN'S OR SUPPLIER'S CODE in item 8 should be completed by entering the number agreed upon with the insurance carrier which handles medical insurance benefits.

The physician or supplier, or an authorized representative of either should sign in item 13. Podiatrists enter their degree on the line after "other degree."





GROUP PRACTICE PREPAYMENT PLAN MANUAL REVISION

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Social Security Administration
HIM-8

HEALTH INSURANCE FOR THE AGED

August 1969

No. 1

<u>New Material</u>	<u>Page No.</u>	<u>Replaced Pages</u>
Manual Check Sheet Sec. 314-318	(1 p.) 41-42 (2 pp.)	-- 41-42 (2 pp.)

Check Sheet.--A check sheet has been furnished for manual holders to provide a record of manual revisions received.

Section 316, Computation of the Annual Deductible for Reimbursement Purposes, has been revised to indicate that plans where the average age of the Medicare membership is 75 or older are now included among those requiring prior authorization from SSA to use the standard deductible allowance.

This section has also been revised to indicate that the equivalent average value of the \$50 deductible under the Medicare program, when spread over all eligible enrollees, has been determined to be an estimated \$33 for calendar year 1970 (rounded to the nearest dollar) as the appropriate figure to be used for those group practice prepayment plans which do not have adequate records to compute the annual deductible. This amount takes into account the carryover provisions of the act.

You will note that this figure is higher than the corresponding amount of \$30 that has been used to date. This is based on current operating data, as well as additional data received from the Current Medicare Survey.

In view of the above, plans may wish to consider changes in the pro rata amounts which are credited to each Medicare beneficiary. See section 318 for detailed instructions.

Thomas M. Tierney, Director
Bureau of Health Insurance

SEE OTHER SIDE

ACTION NOTE: On page 8, change the phone number for the Charlottesville Regional Office to 703-296-5171, extension 452.

Changed material is indicated in the margin of page in the following manner:

┌	┐	= Line on which change begins
or		
└	┘	= Line on which change ends

Revision transmittal sheets should be filed at the end of the manual as a record of receipt.

This Check Sheet should be placed at the front of the Manual immediately before Chapter I, to provide a record of Manual revisions received. These Manual revisions will be issued under cover of numbered "Revision Transmittals."

Trans.
No. Date

1. 8/69

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

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Trans.
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21. _____

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33. _____

34. _____

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36. _____

37. _____

38. _____

39. _____

40. _____

before the conditions in the by-laws are substituted for the authorization. Where the plan must secure an authorization from the enrollee, it may do so at the time a charge is paid by the plan but before reimbursement is requested from the carrier.

C. The plan must request payment on an SSA-1490, Request for Medicare Payment (§ 499, Exhibit 2) or SSA-1490U, Request for Payment by Qualified Organizations (§ 499, Exhibit 3), submitted to the Part B carrier. The plan completes Part I of the form, which need not be signed by the enrollee. The plan should furnish sufficient itemization of the services it has paid for (with dates of service, places of service, and charges) to enable a reasonable charge determination to be made. This may be done by submitting Part II signed by the physician or an itemization on the physician's bill form.

D. Where the SSA-1490 rather than the SSA-1490U is used, a statement on the plan's letterhead should be attached to each request for payment above the signature of a responsible officer or employee of the plan, substantially as follows:

I request payment of Part B benefits on behalf of (name of plan), hereinafter referred to as 'the plan', in accordance with approval #----- I certify in connection with this request that the enrollee named above has been furnished the services described in this claim, and that:

a. the plan has paid in full the amount of the charges for the services shown on this claim;

b. the plan has the enrollee's written authorization to receive Part B benefits due on the basis of bills paid in full by the plan;

c. the plan relieves the enrollee of liability for payment for the services specified in this claim, and will not seek any reimbursement from him with respect to such services, if any Part B benefit is paid to the plan on this claim.

/s/

Title

The enrollee's name and HI number, and the current date, should be entered above the statement.

Where under this provision the plan is advised that all or a portion of the charge was used to meet the \$50 Part B deductible, the plan may include the amount thus credited toward the deductible in its care costs in determining reimbursement from SSA. Costs of such services will also be used in the computation of the weighted average deductible.

314. NONCOVERED ITEMS OR SERVICES AND NONCOVERED COSTS

Section 200 provides a list of items and services which are reimbursable under the Social Security Act. Sections 225ff. are concerned with those items and services which are not reimbursable under the Act. No plan may include in its costs expenses incurred by a Medicare beneficiary for items and services listed in § 225ff.

The administrative costs for furnishing noncovered services and those operating costs not related to patient care, e.g., expenses incurred in soliciting enrollments, etc., are not reimbursable.

Plans will also be required to reduce their total costs by such income as is realized from fees charged for rendering medical services to non-plan members, or by the cost of rendering such services if such cost is determinable. Services furnished to non-members of the plan on a fee basis are reimbursed on a reasonable charge basis through the area carrier (see § 418).

316. COMPUTATION OF THE ANNUAL DEDUCTIBLE FOR REIMBURSEMENT PURPOSES

Section 1833(b) of the Act provides that before an individual can be reimbursed under Part B for medical services, he must have incurred an annual deductible of \$50 for covered medical expenses. Accordingly, a plan which elects to be reimbursed directly by the Social Security Administration must reduce its reimbursable costs for making covered services available to Part B beneficiaries, by an amount representing the deductible.

A member of a GPPP who attains age 65 subsequent to the beginning of the plan's accounting period or who leaves the plan before the end of the year must meet the same deductible as the other members of the plan.

The Social Security Administration has determined that in a GPPP setting a 12 month fiscal period other than a calendar year can be equated to a calendar year period for the computation of the deductible and the deductible carryover. Thus a plan will determine the value of the deductible on its own fiscal year period, and it will apply the utilization of services for the last three months of its fiscal year to determine the value of the carryover. Thus, if a plan is on an April 1 through March 31 fiscal year it will compute the value of the deductible based on the experience of its plan members for that period. The value of the carryover will be based on experience for the months January, February, and March.

Because GPPP's do not ordinarily determine a cost for each service rendered an individual enrollee, a method was devised to determine an amount equivalent to each enrollee's care costs of \$50 or less during the period. The first step is to determine the average cost of a medical visit. The statistical records of the GPPP are then used to determine how many beneficiaries had no visits, how many had one visit, how many had two visits, how many had three visits, and so forth until the equivalent of visits valued at \$50 is reached, as in the following example.

245 utilized no services
100 utilized 1 service
85 utilized 2 services
67 utilized 3 services
503 utilized 4 or more services

\$31,508.50 divided by 1,000 enrollees—\$31.58, the average deductible per Medicare beneficiary.

When a plan does not have adequate records to compute the annual deductible, a standard amount will be allowed for each beneficiary. For calendar year 1966, which includes only the 6 month period from July 1—December 31, 1966, the standard deductible was established as \$23.00 per beneficiary. For years 1967 through 1969, the standard deductible was established as \$30.00. For years starting with 1970, the standard deductible has been established as \$33.00. This amount is subject to change based on information gathered as to the average value of the deductible under Medicare. Notification of such change will be sent to GPPP's at least 90 days before the close of the calendar year and will be effective the first day of the next calendar year. Plans having a high percentage of welfare beneficiaries in their age 65 and over population, or plans where the average age of the Medicare membership is 75 or older, will not be permitted to use the standard deductible allowance without prior authorization from the Social Security Administration.

316.1 Computation of the Carryover Deductible.—Expenses incurred in the last three months of the previous year which were applied toward the deductible for that year may also be applied against the deductible for the current year.

A GPPP which computes its own deductible may reduce its computed deductible by an amount representing the average carryover of its Medicare members. The amount of the carryover should be based on the number of medical visits per beneficiary made during the last three months of the previous year which would have been applied toward the deductible.

Example

Assume that a plan has a total of 10,000 enrollees, 1,000 of whom are Medicare beneficiaries. By dividing the cost of providing covered medical visits by the total number of visits for such medical services, the plan determines that the average cost per visit, after adjustment for time factor, is \$13.50.

Based on the records of individual Medicare beneficiaries enrolled in the plan, it is determined that the following distribution of utilization occurred for the 1,000 Medicare beneficiaries.

245 x 0 x \$13.50—	\$ 0
100 x 1 x \$13.50—	1,350.00
85 x 2 x \$13.50—	2,295.00
67 x 3 x \$13.50—	2,713.50
503 x \$50 —	25,150.00
	<hr/>
	\$31,508.50

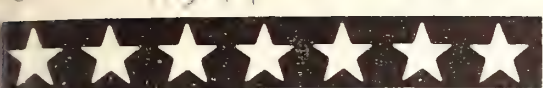
The amount of the carryover means the amount incurred per beneficiary during the last three months which, when added to the amount incurred during the first nine months, would equal \$50.00 or less for the year. The amount would be computed on the basis of the average cost per visit for that year. Only the amount incurred during the last three months is taken into account. The date of service determines when the expenses were incurred.

A plan may use any method to compute the carryover which best suits its operations provided such method produces acceptable results. If the number of Medicare beneficiaries enrolled in the plan is too large to include all beneficiaries in the computation, the plan may propose the use of a statistical sample which would be subject to review and approval by SSA.

318. PRO-RATA DEDUCTIBLE FOR BENEFICIARY RECORD

Each Part B beneficiary enrolled in a direct dealing GPPP is responsible for a proportionate share of those covered costs not reimbursed the plan because of the Medicare deductible and coinsurance. That portion of the monthly premium which a beneficiary pays (or has paid on his behalf) to the plan to cover the cost of the deductible and coinsurance will be credited toward the individual's Part B deductible record. This figure has significance only when a plan member receives services outside the plan. In that case, the accumulated amount credited to the enrollee's deductible record will determine his deductible status for reimbursement for the services received outside the plan.





GROUP PRACTICE PREPAYMENT PLAN MANUAL REVISION

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Social Security Administration
HIM-8

HEALTH INSURANCE FOR THE AGED

DECEMBER 1969

No. 2

New Material

Page No.

Replaced Pages

Sec. 306.2-306.4

36.1 (1 p.)

Section 306.4, Indirect Administrative Costs.--The guidelines for allocating indirect administrative costs for reporting periods beginning on or after January 1, 1969, have been revised. Under the revision, a plan can select one of three methods for allocation of these costs; i.e., allocation on a per capita basis using individual plan members as a unit of allocation; allocation on a per capita basis using the number of contract holders as a unit of allocation; or allocation on the basis of utilization of services.

Thomas M. Tierney, Director
Bureau of Health Insurance

Action Note: Delete existing sections 306.2, 306.3, 306.4, on page 36.

306.2 Administrative Costs.--Administrative costs are recognized as being ordinary and necessary costs in the operation of a plan. To provide a suitable basis for allocation, administrative costs must be broken down into two categories--direct and indirect costs. Costs related to functions covered under the plan's Section 1874 agreement with the Social Security Administration must be kept separately and will be reimbursed separately. (See Section 370.)

306.3 Direct Administrative Costs.-- Direct administrative costs include those associated with medical care expenses in a clinic or other medical setting such as depreciation on furniture and fixtures, maintenance of clinic, supplies used in providing clinic services, taxes on clinic building, etc. These would be added into the direct costs associated with providing medical care and be allocated accordingly.

306.4 Indirect Administrative Costs.--Indirect administrative costs, on the other hand, are not directly associated with providing medical care. Such costs would include, but would not be limited to, salaries of officers, executives, and general office personnel; travel; legal and auditing fees; office building supplies; telephone and telegraph expenses; postage; taxes; and subscriptions to publications and dues for appropriate organizations.

Because the methods by which the various group practice prepayment plans operate differ, the basis for allocating indirect administrative costs between Medicare beneficiaries and other plan members cannot be limited to one particular basis of allocation. Therefore, a plan can select one of the three following methods which it believes is most appropriate to its method of operation:

1. Allocation on a per capita basis using individual plan members as the unit of allocation.
2. Allocation on a per capita basis using the number of contract holders as the unit of allocation.
3. Allocation on the basis of utilization of services.

The time factor will not be allowed as a component of any of the above methods.

This change in methods of allocating administrative costs will be effective for reporting periods starting January 1, 1969, or thereafter. For periods prior to January 1, 1969, such costs must be allocated on a per capita basis.

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no. 9



**HEALTH
INSURANCE
FOR THE AGED**



U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Social Security Administration

HIM-9 (10-68)

**OUTPATIENT
PHYSICAL
THERAPY
PROVIDER
MANUAL**

Health Insurance for the Aged

MEDICARE

OUTPATIENT PHYSICAL THERAPY PROVIDER MANUAL

USING THE OUTPATIENT PHYSICAL THERAPY PROVIDER MANUAL

Use It for Reference

The manual covers not only routine information for your day-to-day operations but tries to anticipate infrequent situations that could occur. It has been indexed for ease of reference.

Keep It Available

Pages are punched for any standard-size three-ring binder. Keep it handy and ask for as many extra copies as you need.

Keep It Up-to-Date

Insert or replacement pages and supplements for additions and revisions will be furnished through your intermediary. Maintain a control on all manuals to assure immediate updating.

OUTPATIENT PHYSICAL THERAPY MANUAL

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FOREWORD

This manual is designed for use by rehabilitation agencies, public health agencies, and clinics, which will be billing for services furnished under the provisions of the Health Insurance for the Aged Act (Medicare). It contains informational and procedural material the agencies and clinics will need to assist in prompt and efficient payment of claims and to answer questions which patients may ask about the program. This issuance should help to assure that the law is uniformly applied nationally without regard to where covered services are furnished. The agency's intermediary will issue any necessary additional instructions on matters which concern the relationship between agencies and intermediaries. The same is true for clinics and carriers.

The manual does not have the effect of regulations, but a careful effort has been made to insure that the provisions of the law and proposed regulations are accurately reflected.

The procedures described in this manual have been devised to satisfy the administrative needs of the program with a minimum of inconvenience to beneficiaries, and to providers and their intermediaries and carriers. We believe that the vast majority of claims will lend themselves to simple, routine handling.

The manual is designed to accommodate new pages as further interpretations of the law and changes in procedures are made. Accordingly, supplements and revised sections, pages or chapters will be issued as the need presents itself.

Your intermediary or carrier will answer any questions you may have about policies and procedures in the program. Agencies or clinics dealing directly with the Social Security Administration may direct questions to the servicing social security district office for reply or refer them to the Bureau of Health Insurance Regional Representative.

THOMAS M. TIERNEY
Director, Bureau of Health Insurance

CHAPTER I

GENERAL INFORMATION ABOUT THE PROGRAM

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The Medicare Program

100. INTRODUCTION

The Health Insurance for the Aged Act, Title XVIII of the Social Security Act, known as "Medicare," has made available to nearly every American 65 years of age and older a broad program of health insurance designed to assist the Nation's elderly to meet hospital, medical, and other health costs. The program includes two related health insurance programs--hospital insurance (Part A of the law) and medical insurance (Part B of the law).

102. HOSPITAL INSURANCE (PART A)

An individual who has applied for and has been determined to be entitled to monthly social security benefits or railroad retirement benefits (although he may not actually be receiving benefit payments, e.g., he has not retired), is automatically entitled to hospital insurance (Part A of the law) beginning with the first day of the month he attains age 65. In addition, a special transitional provision of the law permits persons 65 years and over, who could not qualify for monthly social security or railroad benefits, to obtain hospital insurance upon filing an application.

The hospital insurance program is designed to help patients defray the expenses incurred for hospitalization and related care by reimbursing participating providers of services for the reasonable cost of furnishing covered services. In addition to inpatient hospital services, hospital insurance covers the reasonable cost of post-hospital care furnished by participating extended care facilities and home health agencies.

104. MEDICAL INSURANCE (PART B)

To obtain medical insurance (Part B) coverage, an individual must voluntarily enroll in the plan and pay the required premiums.

The medical insurance plan is designed to supplement the basic coverage of the hospital insurance plan by providing reimbursement (after a yearly \$50 deductible has been met) for 80 percent of the reasonable charge (or of the reasonable cost if the service is furnished by a participating provider of services) for the following specified medical and other health services:

1. Physicians' services, including surgery, consultation, and home, office, and institutional calls, and services and supplies furnished incident to a physician's professional service;
2. Outpatient hospital services furnished incident to physicians' services;

3. Outpatient diagnostic services furnished by a hospital;
4. Outpatient physical therapy;
5. Diagnostic x-ray tests, laboratory tests, and other diagnostic tests;
6. X-ray, radium, and radioactive isotope therapy;
7. Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;
8. Rental or purchase of durable medical equipment for use in the patient's home;
9. Ambulance service;
10. Prosthetic devices which replace all or part of an internal body organ;
11. Leg, arm, back and neck braces and artificial legs, arms, and eyes.

Medical insurance also supplements the basic hospital insurance coverage by providing reimbursement for additional home health care.

106. FINANCING HOSPITAL INSURANCE PROGRAM

The hospital insurance program is financed through separate payroll contributions paid by employees, employers, and self-employed persons. The proceeds are earmarked for the Federal Hospital Insurance Trust Fund to keep them separate from other social security contributions. The law permits their use only for the payment of hospital insurance benefits and administrative expenses. The cost of providing hospital insurance benefits to persons who are not social security or railroad retirement beneficiaries is met by appropriations to the Federal Hospital Insurance Trust Fund from general revenues.

108. FINANCING SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

The supplementary medical insurance plan is financed by the monthly premiums of those who enroll under the plan, matched by an equal contribution from general revenues. All premiums and Government contributions for this plan are placed in a separate fund known as the Federal Supplementary Medical Insurance Trust Fund. This fund is devoted exclusively to the payment of medical insurance benefits and administrative expenses.

Administration of Medicare Program**110. FEDERAL GOVERNMENT ADMINISTRATION OF THE HEALTH INSURANCE PROGRAM**

The Department of Health, Education, and Welfare has been given overall responsibility for administration of the hospital insurance and medical insurance programs. Three major agencies of the Department are involved. The Social Security Administration has the responsibility for policy formulation and the general management and operational aspects of the program. The Public Health Service has the principal responsibility for the professional health aspects of the program. The Social and Rehabilitation Service has the primary role in all aspects of hospital and medical insurance program administration affecting public welfare agencies.

The law specifically prohibits the Federal Government from exercising supervision or control over the practice of medicine, the manner in which medical services are provided, and the administration or operation of medical facilities. The patient is free to choose any qualified institution, agency, clinic, or person offering him services. The responsibility for his treatment and the control of his care remains with his physician and the organization furnishing him services. The individual may keep or obtain any other health insurance available, if he desires.

111. THE HEALTH INSURANCE BENEFITS ADVISORY COUNCIL

A Health Insurance Benefits Advisory Council consisting of persons outstanding in hospital, medical, and other health activities, persons who are representative of professional organizations and associations in the field of medicine, and at least one representative of the general public, advises the Secretary on general policy in administering the program and in the formulation of regulations. The Secretary must consult with the Council in determining conditions of participation for providers of services in addition to the requirements specifically enumerated in the law. The Council also studies the utilization of medical services under the program and makes any recommendations to the Secretary and to Congress that it considers appropriate.

112. STATE AGENCIES

The States are accorded important administrative functions to the extent that each is willing and able to undertake them by agreement with the Secretary.

A. Certifications are made by State agencies to the Department of Health, Education, and Welfare indicating whether providers of services, including clinics, rehabilitation agencies, and public health agencies providing outpatient physical therapy services, meet and continue to meet their respective conditions of participation. This function is intended to be a natural adjunct to ongoing State activities, such as licensing of health facilities and other standard setting activities.

B. Consultation services are rendered by State agencies if their agreements provide for it. Consultation with hospitals, extended care facilities, home health agencies, clinics, rehabilitation agencies, and public health agencies that need and request assistance to meet the conditions of participation is an integral part of the certification process.

C. The State coordinates its activities under the Medicare program with the various other programs in the State that have to do with payment for health care, quality of care, and distribution of health facilities. Coordination of such activities is designed to utilize existing State facilities and trained personnel effectively and economically and to prevent duplication of effort.

D. Where a State enters into an agreement with the Federal Government, as a medical insurance carrier, to pay the medical insurance premium on behalf of its aged welfare recipients, the agreement may provide for a designated State agency to serve as an intermediary on behalf of its welfare recipients.

115. INTERMEDIARIES AND CARRIERS

The Part A intermediary is a national, State, or other public or private agency or organization which has entered into an agreement with the Social Security Administration to process Medicare claims received from providers of services. (Providers may choose to deal directly with SSA rather than with an intermediary.) The Part A intermediary makes payment to hospitals, extended care facilities, and home health agencies for items and services covered under both Part A and Part B. **Effective July 1, 1968, Part A intermediaries also make payments under Part B to rehabilitation agencies and public health agencies that have been approved to furnish outpatient physical therapy services.** Reimbursement to participating providers is made on the basis of reasonable cost determinations. These intermediaries also make payments for certain services provided by nonparticipating hospitals. In addition to making payments, the intermediary assists in the application of safeguards against the unnecessary use of covered services. It

may also furnish consultative services to assist providers to establish and maintain necessary fiscal records, serve as a center for communication with providers, and make audits of provider records.

The law requires the Secretary to contract with selected carriers to perform specified administrative functions under the medical insurance (Part B) program. A principal function of the Part B carrier is to determine whether charges by physicians (including provider-based physicians), suppliers, and nonparticipating extended care facilities are reasonable and to make payment. Effective July 1, 1968, carrier functions also include making Part B payments on a reasonable cost basis to participating clinics for outpatient physical therapy services furnished to Medicare patients.

Carriers are generally assigned to serve a geographical area in which medical services are furnished. All clinic providers located within the geographic area services by a Part B carrier will be serviced by that carrier. However, claims of railroad retirement beneficiaries are processed by The Travelers Insurance Company regardless of where services are furnished, and welfare recipients may be served by a State welfare agency (§ 112).

Disclosure

120. DISCLOSURE OF HEALTH INSURANCE INFORMATION

Records and information acquired in the administration of the Social Security Act are confidential and may be disclosed only under the conditions prescribed in rules and regulations or on the express authorization of the Commissioner of Social Security. The regulations of the Department of Health, Education, and Welfare regarding the confidentiality of records and information apply to governmental and private agencies participating in the administration of the program; to institutions, facilities, agencies, clinics, and persons providing services; and to those furnishing services under arrangements with a provider of services.

Information furnished specifically for purposes of a claim under the health insurance program is subject to these rules and regulations. Such information includes the individual's health insurance claim number, the fact of his entitlement to health insurance benefits, and medical and other information obtained from the Social Security Administration or an intermediary.

However, the information in the provider's own medical records of a patient is not subject to these rules and regulations even though the patient receives benefits under the health insurance program. These records are subject to the requirements of confidentiality in the "Conditions of Participation for Clinics, Rehabilitation Agencies, and Public Health Agencies," and may also be subject to State or local laws or provider rules governing disclosure.

A provider may disclose records or information acquired under the health insurance program only when the record or information is to be used in connection with a claim for health insurance benefits; and the disclosure is necessary for the proper performance of the duties of any officer or employee of (1) the Department of Health, Education, and Welfare, or (2) any public or private agency or organization under an agreement with the Secretary of Health, Education, and Welfare.

A State agency certifying providers in the health insurance program may disclose to the State licensing authority information furnished by a provider relating to the provider's compliance or noncompliance with the licensure requirements. Prior approval by the Department of Health, Education, and Welfare is a condition for such disclosure.

The Social Security Administration has issued guidelines for intermediaries in arranging to supply billing information to State public welfare agencies when payment of the cost of provider services is to be made under both the health insurance and State welfare programs. State public welfare agencies which have entered into agreements with Medicare intermediaries will make any necessary arrangements with the providers involved.

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Outpatient Physical Therapy Services

200. OUTPATIENT PHYSICAL THERAPY SERVICES FURNISHED BY PROVIDERS

Beginning July 1, 1968, outpatient physical therapy services are reimbursable under the medical insurance program (Part B). Patients with medical insurance coverage are entitled to have payment made on their behalf for 80 percent of the reasonable cost of covered outpatient physical therapy services when furnished by a participating provider of services or by others under arrangements with and under the supervision of such a provider. A participating provider of services is a hospital, extended care facility, home health agency, clinic, rehabilitation agency, or public health agency which has entered into an agreement with the Secretary of Health, Education, and Welfare to participate in the Medicare program.

Where physicians have a financial arrangement (e.g., a salary or percentage arrangement, etc.) of the kind referred to in section 405.480(c) of the regulations on Reimbursement for Services by Hospital-Based Physicians, HIR-4, with a provider of physical therapy services, those regulations will, to the extent they are applicable, govern reimbursement.

202. SERVICES FURNISHED UNDER ARRANGEMENTS WITH PROVIDERS

A provider may make arrangements with others to furnish covered outpatient physical therapy. When such arrangements are made, receipt of payment by the provider for the arranged services must (as with services provided directly) relieve the beneficiary or any other person of further liability to pay for the services.

When a clinic, rehabilitation agency, or public health agency provides outpatient physical therapy under an arrangement with others, the services must be furnished in accordance with the terms of a written contract, which provides that the clinic or agency retains responsibility for and control and supervision of such services. The terms of the contract include at least the following:

A. Provide that physical therapy services are to be furnished in accordance with the plan of care established by the physician responsible for the patient's care and may not be altered in type, amount, or duration by the therapist (except in the case of an adverse reaction to a specific treatment).

B. Specify the geographical areas in which the services are to be furnished.

C. Provide that personnel and services contracted for meet the same requirements as those which would apply if the personnel and services were furnished directly by the clinic, rehabilitation agency, or public health agency.

D. Provide that the therapist will participate in conferences required to coordinate the care of an individual patient.

E. Provide for the preparation of treatment records, with progress notes and observations, and for their prompt incorporation into the clinical records of the clinic or agency.

F. Specify the financial arrangements. The contracting organization or individual may not bill the patient or the health insurance program.

G. Specify the period of time the contract is to be in effect and the manner of termination or renewal.

205. CONDITIONS FOR COVERAGE OF OUTPATIENT PHYSICAL THERAPY SERVICES

Outpatient physical therapy services furnished a beneficiary by a participating provider are reimbursable only when furnished in accordance with the following conditions.

205.1 Physician's Certification and Recertification.--

A. Content of the Physician's Certification.--No payment may be made for outpatient physical therapy services unless a physician certifies that:

1. the physical therapy services are or were required by the patient on an outpatient basis (see § 205.2);

2. a plan for furnishing such services is or was established and periodically reviewed by the physician (see § 205.4);

3. the outpatient physical therapy services are or were furnished while the patient was under the care of a physician (see § 205.3).

Since the certification is closely associated with the plan of treatment, the same physician who establishes the plan must certify to the necessity for outpatient physical therapy services. Certification should be obtained at the time the plan of treatment is established or as soon thereafter as possible. "Physician" means a doctor of medicine or osteopathy (including an osteopathic practitioner) legally authorized to practice by a State in which he performs the function. The services performed by physicians within this definition are subject to any limitations imposed by the State on the scope of practice.

B. Recertification.--When outpatient physical therapy services are continued under the same plan of treatment for a period of time, the physician must recertify at intervals of at least once every 30 days that there is a continuing need for such services and should estimate how long services will be needed. The recertification should be obtained at the time the plan of treatment is reviewed since the same interval (at least once every 30 days) is required for the review of the plan. Recertifications must be signed by the

physician who reviews the plan of treatment. The form of the recertification and the manner of obtaining timely recertification is up to the individual clinic or agency.

C. Method and Disposition of Certifications.--There is no requirement that the certification or recertification be entered on any specific form or handled in any specific way as long as the intermediary or carrier can determine, where necessary, that the certification and recertification requirements are met. The certification by the physician will be retained by the clinic, rehabilitation agency or public health agency, but the agency or clinic must certify on the billing form that the requisite certification and recertifications have been made by the physician and are on file in the clinic or agency when it forwards the request for reimbursement to the intermediary.

D. Delayed Certification.--The clinic or agency should obtain certifications and recertifications as promptly as possible. Payment will not be made unless the necessary certifications have been secured. In addition to complying with the usual content requirements, delayed certifications and recertifications must include an explanation for the delay and any other evidence the clinic or agency considers necessary in the case. The format of delayed certifications and recertifications and the method by which they are obtained will be left to the clinic or agency.

205.2 Outpatient Requirement.--Outpatient physical therapy is reimbursable only when furnished by a provider to its outpatients, i.e., to patients in their homes, to patients who come to the facility's outpatient department, or to inpatients of other health facilities. Thus, if the agency or clinic has inpatient facilities, it may not furnish covered outpatient physical therapy services to its inpatients. However, since the inpatients of one institution may be considered the outpatients of another participating provider, a provider may furnish covered outpatient physical therapy to inpatients of another health facility.

205.3 Outpatient Must Be Under the Care of a Physician.--Outpatient physical therapy must be furnished to an individual who is under the care of a physician. There must be evidence in the clinical record of the patient that he has been seen by a physician at least every 30 days. If the patient has not been seen by the physician within a 30-day period, the clinic, rehabilitation agency, or public health agency is responsible for contacting the physician. This physician may be the patient's private physician; or, a physician on the staff of the clinic, rehabilitation agency or public health agency; or, a physician associated with an institution which is the patient's residence; or, a physician associated with a medical facility

in which the patient is an inpatient. The attending physician establishes the plan of treatment and also makes the necessary certifications (see §§ 205.1 and 205.4).

205.4 Outpatient Physical Therapy Services Furnished Under a Plan.--

Outpatient physical therapy must be furnished under a plan established and periodically reviewed by a physician. The plan must be established (that is, reduced to writing either by the physician who makes the plan available to the clinic, rehabilitation agency, or public health agency, or by the agency or clinic itself when it makes a written record of the physician's oral orders) before treatment is begun. The plan should be promptly signed by the ordering physician and incorporated into the agency's or clinic's permanent record for the patient.

The plan must relate the type, amount, frequency, and duration of the physical therapy services that are to be furnished the patient and indicate the diagnosis and anticipated goals. Any changes should be made in writing and signed by the physician or by a qualified physical therapist, registered professional nurse, or physician on the staff of the agency or clinic pursuant to the attending physician's oral orders.

The plan must be reviewed by the attending physician, in consultation with the physical therapist(s) of the clinic, rehabilitation agency, or public health agency, at such intervals as the severity of the patient's condition requires, but at least every 30 days. Each review of the plan should contain the initials of the physician and the date performed. The patient's plan normally need not be forwarded to the intermediary for review but will be retained in the agency's file. The clinic, rehabilitation agency, or public health agency must certify on the billing form that the plan is on file (see § 315.1, item 22, and § 320.2, item 14).

210. DEDUCTIBLE AND COINSURANCE UNDER MEDICAL INSURANCE

210.1 Deductible---In each calendar year a deductible of \$50 must be satisfied before payment can be made under the medical insurance program. Under a carryover provision, expenses incurred in the last 3 months of the previous year which were applied toward the medical insurance deductible for that year may also be applied against the deductible for the current year. Except to the extent that the prior year's expenses are counted, the deductible is satisfied by the initial medical insurance expenses incurred in the current year.

Bills count toward the deductible on the basis of incurred rather than paid expenses. Noncovered expenses do not count toward the deductible. Even though an individual is not eligible for the entire calendar year, i.e., his insurance coverage begins after the first month of the year or he dies before the last month of the year, he is still subject to the full \$50 deductible. Medical expenses incurred in the portion of the year preceding entitlement to medical insurance may not be credited toward the deductible.

Before charging the patient for any part of the deductible, the clinic or agency should attempt to ascertain whether the patient has already satisfied the deductible for the current calendar year (see § 310).

210.2 Coinsurance.--After sufficient expenses have been incurred to satisfy the deductible, the agency or clinic will be reimbursed by the program for 80 percent of the reasonable cost of the covered outpatient physical therapy services which it provided directly or through arrangements with others. The patient is responsible for a coinsurance amount of 20 percent of the reasonable charge for the outpatient physical therapy services furnished.

General Exclusions From Coverage

230. GENERAL EXCLUSIONS

No payment can be made under the health insurance program for certain items and services as indicated in the following sections (§§ 231-239).

231. SERVICES NOT REASONABLE AND NECESSARY

Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are not covered.

232. NO OBLIGATION TO PAY FOR OR PROVIDE SERVICES

Program payment may not be made for items or services which neither the beneficiary nor any other person or organization has a legal obligation to pay for or provide. This exclusion applies where items and services are furnished gratuitously without regard to the individual's ability to pay, and without expectation of payment from any source, such as free x-rays or immunizations provided by health organizations.

However, Medicare coverage is not excluded where a third party, rather than the patient is obligated to pay for or provide the items and services. Furthermore, reimbursement is not precluded merely because a provider waives his charge in the case of a particular patient or class of patients. The waiver of charges for some patients does not impair the right to charge others, including Medicare patients. The determinative factor is the reason the particular individual is not charged.

232.1 Indigency.--This exclusion does not apply where items and services are furnished an indigent individual without charge because of his inability to pay, if the provider bills other patients to the extent that they are able to pay.

232.2 Provider Bills Only Insured Patients.--Many providers waive their charges for individuals of limited means, but they also expect to be paid where the patient has insurance which covers the items or services they furnish. In such a situation benefits are payable for services rendered to Medicare patients. The same holds true when treatment is financed by a private research foundation and the patient is not expected to pay for his treatment unless he has insurance.

232.3 Medicare Patient Has Other Insurance.--Payment is not precluded under Medicare even though the patient is covered by another health insurance plan or program which is obligated to provide or pay for the same services. The plan may pay money toward the cost of the services, such as a health insurance policy, or it may organize and maintain its own facilities and professional staff, such as employer and union sponsored plans and group practice prepayment plans.

However, services which are covered under a workmen's compensation policy are specifically excluded from coverage under Medicare. (See §§ 236 and 245ff.)

232.4 Third Person Liability.--Services are covered by Medicare even though the patient's need for treatment for an injury resulted from the negligence of another party who is or may be legally liable for the patient's medical expenses. The existence of the other person's liability does not affect the patient's obligation to pay for the services he receives.

232.5 Members of Religious Orders.--A legal obligation to pay exists where a religious order either pays for or furnishes services to members of the order. Although medical services furnished in such

a setting would not ordinarily be expressed in terms of a legal obligation, the order has an obligation to care for its members. Thus, payment may be made for such services whether they are furnished by the order itself or by independent sources that customarily charge for their services.

233. ITEMS AND SERVICES FURNISHED OR PAID FOR BY GOVERNMENT INSTRUMENTALITIES

The Medicare law limits the circumstances under which payment may be made for items and services furnished or paid for by State, local, or Federal Government instrumentalities. The law applies separate limitations applicable to items and services which the provider is obligated under a Federal Government contract or law to furnish at public expense (see § 233.1) and items and services paid for directly or indirectly by a State, Federal, or local government entity (see § 233.2).

233.1 Items and Services Which the Provider Is Obligated to Furnish Under a Federal Government Contract or Law.--Payment may not be made for items or services which a provider is obligated to render at public expense by law of, or contract with, the United States.

233.2 Items and Services Which Are Paid for Directly or Indirectly by a Government Entity.--

A. General.--Benefits are not payable for items and services paid for by a State, local, or Federal government agency, except as specified in B and C below. This exclusion applies to services furnished by government-operated facilities as well as services furnished by nongovernmental facilities which are paid for by a government agency.

B. Statutory Exceptions.--The exclusion of items and services paid for by a governmental entity does not apply in the following situations; therefore, payment may be made under Medicare where:

1. The items or services are furnished under a health benefits or insurance plan established for employees of the governmental entity;
2. The items or services are furnished under one of the titles of the Social Security Act (such as medical assistance under title XVI or XIX).

C. Exception Approved by the Secretary.--The Secretary of Health, Education, and Welfare is authorized by law to specify additional

exceptions to this exclusion. The Secretary has approved Medicare payment for items or services which are paid for by a State or local governmental entity and furnished an individual as a means of controlling infectious diseases or because the individual is medically indigent.

233.3 Illustrations of Exclusions of Services Covered by Various Governmental Programs.--

A. **Veterans Administration.**--Services furnished without charge by a VA facility are excluded from coverage under Medicare. In addition, the fact that a beneficiary is eligible to have services furnished by private sources paid for by the VA precludes payment for them under Medicare. It will generally be advantageous for health insurance beneficiaries to have services paid for under a VA program where possible since the VA has no deductible or coinsurance requirements.

B. **Government Research Grants.**--A beneficiary who would be eligible to have his care paid for by a governmental research grant can receive benefits under title XVIII if the facility charges those patients who have Medicare or other insurance. Where a provider claims benefits under title XVIII, it may not also accept research grant funds for the services in question, except to the extent of the deductible and coinsurance amounts.

C. **Vocational Rehabilitation Agencies.**--Under the vocational rehabilitation programs of the various States, vocational training and services are provided to handicapped persons who qualify under State law. Where items or services are furnished or paid for by a State VR agency, title XVIII benefits are payable only if the agency makes services available without cost because of the individual's medical indigency or as a means of controlling infectious diseases.

D. **State or Local Health Department Clinics.**--Many State or local health departments operate outpatient clinics. Services rendered by such clinics free of charge because of the individual's indigency or as a means of controlling infectious diseases (e.g., city-operated charity clinics) are covered under title XVIII.

E. **Civilian Health and Medical Program of the Uniformed Services (Military Medicare).**--This program provides both hospitalization and outpatient care in civilian facilities for spouses and children of active duty members of the uniformed services, retired service-men, and spouses and children of retired and deceased members of the uniformed services.

Retired members of the uniformed services, their spouses and children, or the spouses and children of deceased members, who are not entitled to Part A benefits but who are enrolled in Part B may not receive military medicare benefits for services covered under Part B, except to the extent that benefits are not payable under Part B. Dependents of active duty members of the uniformed services are not governed by the above rules. They have the option of electing to claim benefits under either military medicare or title XVIII. If benefits are paid under military medicare, title XVIII benefits are not payable for the same services, except for charges not covered under military medicare, e.g., the military medicare deductible and coinsurance amounts.

F. Active Duty Servicemen.--In limited circumstances servicemen on active duty may have care incivilian facilities paid for by the armed services. Except for emergency services, prior approval is generally required before such payment can be made. Services furnished pursuant to such approval and services paid for or expected to be paid for are not reimbursable under title XVIII.

234. SERVICES NOT PROVIDED WITHIN THE UNITED STATES

Services which are not provided within the United States are not covered. The United States includes the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

235. SERVICES RESULTING FROM WAR

Items and services which are required as a result of war, or of an act of war, occurring after the effective date of the patient's current coverage are not covered.

236. ITEMS AND SERVICES UNDER A WORKMEN'S COMPENSATION LAW

Items and services to the extent that payment has been made, or can reasonably be expected to be made, under a workmen's compensation law or plan of the United States or a State may not be paid for by the program. (See § 245ff.)

237. ROUTINE SERVICES AND APPLIANCES

Routine physical checkups; eyeglasses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; hearing aids and examinations for hearing aids; and immunizations are not covered.

Routine physical checkups include (a) examinations performed without relationship to treatment or diagnosis for a specific illness,

symptom, complaint, or injury, and (b) examinations required by third parties such as insurance companies, business establishments of Government agencies.

238. CHARGES IMPOSED BY IMMEDIATE RELATIVES OF THE PATIENT OR MEMBERS OF HIS HOUSEHOLD

Payment may not be made for expenses which constitute charges by immediate relatives of the beneficiary or by members of his household.

This exclusion applies only to services reimbursed on a charge basis and does not apply to provider services. Thus, reimbursement may be made for covered services furnished by a provider to an owner of the institution or to an immediate relative of an owner, or a member of an owner's household.

239. PERSONAL COMFORT ITEMS

Items which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member are not covered.

Request for Payment

240. PATIENT REQUEST FOR PAYMENT

Before payment can be made for outpatient physical therapy services, a written request for payment signed by the patient, or by another person qualified to do so on his behalf, must be filed. The signature of the patient or other qualified person may be obtained on the respective SSA billing forms, or, under specified conditions, the provider may obtain a single signature on its records.

240.1 Billing Forms as Request for Payment.--Both of the billing forms (SSA-1483, Provider Billing for Medical and Other Health Services, see § 315.1; and SSA-1490, Request for Medicare Payment, see § 320.1) contain a patient's signature line incorporating the patient's request for payment of benefits, authorization to release information and assignment of benefits. When the billing form is used as the request for payment, it must be signed. The billing form should be forwarded to the intermediary, to the carrier, or, if the provider deals directly with the Government, to the Social Security Administration.

Ordinarily a single signed request will suffice for each outpatient physical therapy plan. However, a subsequent signed request for payment will be required if there is a transfer of the patient's care from one clinic or agency to another.

240.2 Request for Payment on Provider Record.--In lieu of separate signatures on the billing forms, the provider may arrange with its intermediary or carrier to have the patient's signature in the provider's file serve as the request for payment. The pertinent language on the billing forms must be incorporated by printing or stamping on the provider's records. Where this procedure is adopted, the provider should check the block "Contained in provider's record" in item 12 of the SSA-1483. Where the form SSA-1490 is used by a clinic which is a participating outpatient physical therapy provider, these words should be entered in item 6. When the provider has arranged with its carrier or intermediary to put this procedure into effect, the intermediary or carrier will make payment to the provider without the patient's signature on the billing form. The intermediaries and carriers will verify through regular audit activities that the signatures are being obtained as specified.

The following format is suggested for the statement on the provider's record:

**"Statement to Permit Payment to the Provider for Outpatient
Physical Therapy Services**

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. This authorization and request shall apply to the period _____ to _____."

The designated period of time to be entered on the record of the rehabilitation agency, clinic, or public health agency should be appropriate to the circumstances, but should not exceed one year. Some agencies or clinics may wish to restrict the period to accommodate their own billing requirements.

241. EXECUTION OF THE REQUEST FOR PAYMENT

If at all practicable, the patient should sign the request at the time outpatient physical therapy services begin.

In certain circumstances, this is impracticable; for example, when the individual is incompetent or otherwise is in such a condition that he should not be asked to transact any business. In this situation, his representative payee (i.e., a person designated by the Social Security Administration to receive monthly benefits on the patient's behalf),

a relative, legal guardian, or a representative of an institution (other than the provider) usually responsible for his care, or a representative of an institution (other than the provider) usually responsible for his care, or a representative of a governmental entity providing welfare assistance should, if present at time of start of services, be asked and permitted to sign on his behalf.

Refunds

242. REFUNDS TO BENEFICIARY

In its participation agreement the clinic, rehabilitation agency, or public health agency agrees not to charge for items or services for which an individual is entitled to have payment made on his behalf. Thus, when the patient's eligibility is verified, the provider is obliged to refund to the proper party any payments previously collected from beneficiaries, other insurance carriers, welfare, or others for covered outpatient physical therapy services, except for deductibles, coinsurance amounts, and noncovered charges. When the intermediary is aware that the beneficiary previously paid part of the reimbursable medical insurance expenses, the intermediary will deduct that part from the provider reimbursement and will refund the amount to the beneficiary. (See §§ 310; 315.1, Item 21; and 320.2, Items 9, 10, and 11.)

Workmen's Compensation

245. WORKMEN'S COMPENSATION

Payment under Medicare may not be made for any items and services to the extent that payment has been made or can reasonably be expected to be made for such services under a workmen's compensation law or plan of the United States or a State. Moreover, any Medicare payment must be conditioned on reimbursement to the supplementary medical insurance trust fund if payment for the items or services is received under workmen's compensation.

This exclusion applies to the workmen's compensation plans of the 50 States, the District of Columbia, Guam and Puerto Rico, as well as the systems provided under the Federal Employees' Compensation and the U.S. Longshoremen's and Harbor Workers' Compensation Acts. The Federal Employer's Liability Act is not a workmen's compensation law or plan for purposes of this exclusion.

The beneficiary is responsible for taking whatever action is necessary to obtain payment under workmen's compensation where payment under that system can reasonably be expected. Failure to take proper and timely action will preclude payment under the health insurance program

to the extent that payment could reasonably be expected under workmen's compensation if the beneficiary had exercised his benefit rights under that system.

245.1 Effect of Payments Under a Workmen's Compensation Plan.

A. Deductibles and Coinsurance.---Expenses for services covered under workmen's compensation cannot be applied toward the Medicare deductible and coinsurance amounts. Thus, expenses for outpatient physical therapy services do not count toward the Part B deductible if paid for under workmen's compensation, or if such payment is reasonably expected.

B. Workmen's Compensation Payment Does Not Cover All Services.---Certain workmen's compensation programs specify limits on the amount that can be paid for medical care under workmen's compensation. Services provided after these limits have been reached may be paid for under the health insurance program, subject to the deductible and coinsurance requirements. The following policies apply in such cases:

1. The workmen's compensation payment is allocated at the normal workmen's compensation rate of payment to those services covered by workmen's compensation furnished first in time until the workmen's compensation benefit rights are exhausted.

2. Any services covered under Medicare not thus paid for under workmen's compensation may be billed to the health insurance program except for any applicable deductible or coinsurance amounts.

245.2 Provider Handling of Workmen's Compensation Cases.---Information supplied by the provider will be the primary means of alerting intermediaries to actual or potential workmen's compensation coverage in specific cases. The intermediary will undertake necessary additional investigation.

Providers of services are expected to inquire of the beneficiary or his physician at the time the services are ordered, whether the condition is work-related. A condition would be considered to be work-related if: (a) the physician or the patient states that it is work-related; or (b) the condition, or serious aggravation thereof, arose in the course of the individual's employment, e.g., the patient fell from a scaffold while at work; or (c) the diagnosis is one which is commonly believed to result from employment of the kind engaged in by the patient.

A. Workmen's Compensation Coverage Admitted.--Where the patient or his physician indicates (or the provider believes from the medical history) that the "work-related" question on the billing form should be answered affirmatively, the provider should ask the patient or his physician whether workmen's compensation is expected to pay for the services. (Frequently, where services are covered under a workmen's compensation program, the services will be authorized in advance by the workmen's compensation carrier, the physician, or the employer.)

Where the patient or his physician indicates that the services will be paid for by a workmen's compensation program or where the provider is authorized to bill under workmen's compensation, no billing form should be submitted. If it later develops that the workmen's compensation claim is denied or a workmen's compensation claim is not filed within 60 days after the services were furnished, the provider should submit a bill in accordance with the regular billing procedure. In the latter case, the provider should also submit a supplementary statement explaining the circumstances and an authorization signed by the beneficiary or his representative permitting the intermediary to obtain additional information concerning the issue of workmen's compensation from the employer, the workmen's compensation carrier or any other source.

B. Patient or Physician Denies Workmen's Compensation Coverage.--There will be some situations in which the "work-related" question should be answered in the affirmative even though the patient or his physician denies workmen's compensation coverage. For example, the patient may state that he does not wish to report the condition to his employer, or the patient or his physician may state that the services are not covered under workmen's compensation.

A supplementary statement should be attached to the billing form explaining the circumstances and an authorization signed by the beneficiary or his representative permitting the intermediary to obtain additional information concerning the issue of workmen's compensation from the employer, the workmen's compensation carrier, or any other source.

Protests and Appeals

255. PROVIDER PROTEST OF PAYMENT DETERMINATION

The outpatient physical therapy provider and its intermediary should attempt to resolve mutually any differences involving payment for services that arise from the application of the cost formula or the amount payable in a specific case. While no appeal is available for providers from intermediary payment determinations, provider complaints and protests will be considered in Social Security Administration review of the intermediary's or carrier's (for medical clinics) application of the cost formula or its compliance with the other terms of its agreement with the Government.

257. BENEFICIARY APPEALS (PART B)

A. Beneficiary Appeal Rights.--An individual with Part B coverage who is dissatisfied with a request for payment of medical insurance benefits, or with the promptness with which his request for payment is acted upon, is entitled to an opportunity for a review by, and if still dissatisfied, to a fair hearing by the intermediary or carrier. An individual has a right to a hearing by the Social Security Administration on a question of entitlement, i.e., issues relating to the enrollment of a beneficiary under medical insurance (see § 104), rather than the amount payable on a claim. However, there is no legal provision for an appeal to SSA of the final decision of the intermediary or carrier regarding coverage of services or the amount of the medical insurance benefit.

B. Handling Beneficiary Protests.--Patient protests concerning entitlement to Part B benefits, e.g., enrollment, premium payment, should be referred to the social security district office. Protests concerning the denial, amount, or promptness of payment for items or services furnished by the provider under medical insurance, should be handled, if simply amenable to explanation or correction, by the provider. If he is still dissatisfied, the patient should be referred to his social security district office. The district office can offer assistance to the beneficiary in determining his appeal rights and can answer specific questions about the appeal procedures. The district office can also assist the individual in completing the necessary forms for requesting reconsideration or hearing.

CHAPTER III

BILLING PROCEDURES

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300. HEALTH INSURANCE CARD

The Social Security Administration maintains in Baltimore, Maryland, the records of all persons entitled to health insurance. After entitlement is established, each beneficiary is issued a health insurance card by the central office of the Social Security Administration (or in some cases by the Railroad Retirement Board) for use in obtaining hospital insurance benefits, medical insurance benefits, or both. The health insurance claim number on the card is essential in locating the patient's record when a claim for benefit payment is made. No billing form should be forwarded without the correct claim number. It is very important that the claim number on this card be accurately recorded on the billing form since the case cannot be processed if the number is missing or incorrect.

Exhibit 1, § 399, of this chapter shows the health insurance cards and briefly explains the numbering system as an aid in recognizing valid numbers.

The clinic or agency should ask each patient who gives his age as 65 or older for his health insurance card to determine his health insurance entitlement status and obtain the correct health insurance claim number. If a patient is within 3 months of age 65 and has not yet applied for health insurance entitlement, it will be helpful if he, or someone on his behalf, is advised to contact the social security district office. The provider may wish to arrange with the district office to bring such cases routinely to the attention of the district office.

A health insurance card is acceptable without a signature. However, the patient should be asked to sign the card if he has not already done so.

302. CERTIFICATE OF SOCIAL INSURANCE AWARD AND TEMPORARY NOTICE OF ELIGIBILITY

An individual who has not yet received his health insurance card may present one of the following to indicate his health insurance entitlement status.

a. Certificate of Social Insurance Award.--Health insurance beneficiaries receive a Certificate of Social Insurance Award (see Exhibit 2, § 399) showing the health insurance claim number, dates of entitlement to Part A and Part B, and containing the following statement:

"This notice may be used if Medicare services are needed before you receive your health insurance card."

b. **Temporary Notice of Eligibility.**--When a person 65 years or older needs immediate medical services, the social security district office may issue a Temporary Notice of Eligibility (see Exhibit 3, § 399) before a Certificate of Social Insurance Award or health insurance card is issued.

The patient's name and health insurance claim number shown on these notices should be entered on the billing form.

306. UTILIZATION NOTICE OR EXPLANATION OF BENEFITS

If the patient cannot furnish his health insurance card or one of the notices described in § 302, he may have a utilization notice or explanation of benefits which shows his claim number. Such notices are sent to the beneficiary by the Social Security Administration, the intermediary, or the carrier after payments are made under Part A or Part B. These notices, if current, may also indicate to the provider the patient's deductible status under medical insurance.

308. CONTACTS WITH THE SSA DISTRICT OFFICE TO OBTAIN HEALTH INSURANCE CLAIM NUMBERS

When a patient cannot furnish the health insurance claim number, it should be requested from the nearest social security district office. Apart from assisting in determining correct claim numbers, the district office can help a beneficiary to replace a lost health insurance card.

310. DETERMINING HOW MUCH TO CHARGE PATIENT BEFORE BILLING IS SUBMITTED

The patient should be asked if he has any evidence that he has met the deductible, such as an Explanation of Medicare Benefits form (see § 306). The provider may also take into account any other information on the patient's deductible status available to it.

Where the deductible is known to be met, collect 20 percent of the charges for outpatient physical therapy. Where the deductible is known to be met in part, collect no more than the unmet deductible and 20 percent of the remaining charge. When the deductible is not met or its status is unknown, collect no more than \$50 and 20 percent of the balance. Once the provider has billed the intermediary for outpatient physical therapy services, it should not collect or accept any additional money from the patient for such services until the intermediary has notified the provider how much of the deductible has been met. Otherwise, the provider is likely to receive duplicate payments from the patient and the program.

315. BILLING FOR OUTPATIENT PHYSICAL THERAPY SERVICES BY REHABILITATION AND PUBLIC HEALTH AGENCIES

Form SSA-1483, Provider Billing for Medical and Other Health Services, will be used by a **participating rehabilitation agency** or **public health agency** to report outpatient physical therapy services furnished on or after the provider's effective date of participation under the program. Do not use this form for any services other than outpatient physical therapy. Note that the earliest date for which this form can be used is for services furnished on July 1, 1968, or the agency's effective date of participation, whichever is later.

NOTE: See the billing instructions in § 320 if the provider furnishing outpatient physical therapy services is a clinic.

A. When to Submit This Form.--The provider may submit this form on a timely cyclical billing basis. An SSA-1483 should be submitted to the Part A intermediary in all cases where outpatient physical therapy services are rendered, regardless of whether the deductible has or has not been satisfied. No SSA-1483 should be submitted if (1) the patient is not enrolled under Part B, or (2) workmen's compensation will pay the bill. (See §§ 245ff.)

315.1 Completing Items on Form SSA-1483.--

Item 1: Patient Identification. Enter the patient's last name, first name, and middle initial from his health insurance card or other notice.

Item 2: Health Insurance Claim Number. Enter the patient's claim number as shown on his health insurance card, certificate of award, or utilization notice, or as reported by the social security district office.

Item 3: Patient's Address. Show the patient's mailing address from your records. If the patient is an inpatient of another institution, also show "inpatient of (name of institution)."

Items 4 and 5: Date of Birth and Sex. Enter the patient's date of birth and sex. If only the year of birth is available, enter that. If the date of birth is unknown, the provider should transmit the bill without the date of birth. While the date of birth is useful as identification and should be shown when available, a billing can be processed without it.

Items 6, 7, and 8: Provider Identification. Enter the name and address of the provider, including the zip code, and the assigned provider number. These items can be preprinted on all copies of

PROVIDER BILLING FOR MEDICAL AND OTHER HEALTH SERVICES
MEDICAL INSURANCE BENEFITS - SOCIAL SECURITY ACT

Form Approved
 Budget Bureau
 No. 72-R0738

1. Patient's last name <u>Blank</u>	First name <u>Henry</u>	MI <u>N.</u>	2. Health insurance claim number <u>000-00-0000A</u>
3. Patient's address (Street number, City, State, ZIP Code) <u>1078 None Street Anywhere, Maryland 21200</u>			4. Date of birth <u>07-15-95</u>
6. Provider name and address, (City and State) <u>Rehabilitation Center</u> <u>501 High St. Anywhere, Md. 21200</u>			5. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F
7. Provider number <u>50100</u>			9. Type of service A. <input type="checkbox"/> Inpatient C. <input checked="" type="checkbox"/> Other (Specify) <u>Physical Therapy</u> B. <input type="checkbox"/> Outpatient
8. Medical record number			

If you have other health insurance or if your State Medical Assistance Agency will pay part of your medical expenses and you want information about this claim released to them upon their request complete items 10 and 11.

10. Insuring organization or State agency name and address	11. Policy or medical assistance number
12. Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related medicare claim. I request that payment of authorized benefits be made on my behalf.	

<input checked="" type="checkbox"/> Contained in provider's record	Signature (Patient or authorized representative) (Signature by mark must be witnessed)	Date <u>9-1-68</u>
--	--	-----------------------

13. Nature of illness or injury <u>Fractured arm</u>	<input type="checkbox"/> Check here if illness or injury was connected with employment	Do not use this space
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14. Surgical procedures	
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15. Statement of services	Covered Charges	16. Statement Covers Period	First service	Last service
A. Clinic visit ()			<u>09-01-68</u>	<u>09-30-68</u>
B. Emergency room ()		17. Blood Information	A. Pints furnished	B. Pints replaced
C. Laboratory			C. Pints	Not Replaced
D. Radiology		18. Professional component (hospital inpatients)		19. Other professional component
E. Pharmacy		A. Pathology		
F. Blood		20. Date benefits exhausted or HH plan terminated		21. Patient paid (Excluding IFE) <u>\$12.00</u>
G. Ambulance		22. I certify that the required physician's certificate is on file. <u>D. A. Smith</u>		23. Date forwarded <u>09-30-68</u>
H. Physical therapy	60 00	FOR INTERMEDIARY USE ONLY		
I. Other (Specify)		24. Verified Patient Liability		
		A. Blood deductible	B. Cash deductible	C. Coinsurance
J. TOTAL		25. Payment Distribution		26. Date approved <u>10-10-68</u>
	60 00	Provider	Patient	
	48.00			

Remarks:

the form, if desired. Enter the patient's medical record number only if one is assigned by the provider for its own filing purposes.

Item 9: Type of Service. Check "Other." Enter "physical therapy" below item C. Do not check items A or B.

Items 10 and 11: Complementary Coverage Information. If the patient desires that information about the claim be sent to a complementary insurer or welfare agency upon such organization's request and the provider does not object, the name and address of the organization or agency should be shown. The identifying number will be shown in item 11.

Item 12: Patient's Certification. Have the patient or his authorized representative read the statement on the form. The same statement may be incorporated in the provider's own records.

If the signature is obtained on form SSA-1483, it is sufficient if it is legible on the original only. Ordinarily a single signed request will suffice for each outpatient physical therapy plan. If the provider obtains the signature on its own form (see § 240.2), check the block marked "Contained in Provider's Record." The effective period of a signature on the provider's record may not exceed 1 year. Some providers may prefer to restrict the period to accommodate their own billing requirements.

If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf, e.g., John J. Jones by Jack A. Smith. (See § 241.)

Briefly explain why the patient did not sign the form himself and show the relationship of the signer to the patient. This explanation should be retained in the provider's file if the signature is obtained on the provider's own record. If other than the patient's signature is on form SSA-1483, the explanation should accompany or be included on the billing form.

The statement should be read to a patient who signs by mark. A signature by mark should be witnessed by a person who knows the patient. Enter the name and address of any person witnessing a signature by mark.

Item 13: Nature of Illness or Injury. List here, from the patient's medical record, the nature of the illness or injury for which

outpatient physical therapy services were given. Acceptable medical terminology should be used, such as International Classification of Diseases Adapted, Current Medical Terminology, etc.

If the condition was employment related, check the box and show the address of the employer, if known. Where the provider knows that a workmen's compensation claim has been made, it should insert or attach a statement identifying the carrier, if any, handling the workmen's compensation claim and give any available details about the claim. It is not necessary to submit an SSA-1483 if it is known that workmen's compensation will pay the bill. (See § 245.)

Item 14: Surgical Procedures. This item does not apply to outpatient physical therapy and should not be completed.

Item 15: Statement of Services. Enter the covered charges for outpatient physical therapy services during the billing period on Line H. Show the total covered charges on Line J. (This will always be the same as Line H.)

Item 16: Statement Covers Period. Enter the dates of the first and last services furnished during the billing period.

Inclusive dates should not overlap:

1. Period before the provider's effective date of participation;
2. Months before and after the beneficiary was entitled to medical insurance benefits;
3. Two calendar years;
4. September and October, unless the provider knows that the Part B cash deductible was previously met. This is because of the special carryover provision that expenses incurred in the last three months of a year that apply toward the medical insurance deductible for that year may also be applied against the deductible for the next year. (See § 220.2.)

Items 17, 18, 19, and 20: Do not use these items.

Item 21: Patient Paid. Enter amount, if any, paid by the patient for outpatient physical therapy services. Do not include any amount paid by the patient for other services, such as physicians' services and any other Part B services. If the patient's payments exceed his liability, the intermediary will refund the overpayment to the patient and deduct the overpayment from any amount otherwise due the provider.

Item 22: Signature of Provider Representative. Before the billing is forwarded to the intermediary, a provider representative should sign here after assuring himself that a physician's certification as to medical necessity is on file, that the physical therapy plan has been established, the plan is periodically reviewed by a physician, and the plan is in effect during the entire billing period (see §§ 205ff.). A stamped signature is acceptable.

Item 23: Date Forwarded. Enter the date on which the form was forwarded to the intermediary.

The balance of the form is for the use of the intermediary in computing the payment to be made to the provider and/or patient.

320. REQUEST FOR MEDICARE PAYMENT (FORM SSA-1490) FOR OUTPATIENT PHYSICAL THERAPY SERVICES BY CLINICS

This form is used by a **participating clinic** to report outpatient physical therapy services furnished on or after the clinic's effective date of participation under the program. It should be submitted to the Part B carrier.

Note: If the patient is a railroad annuitant, the carrier will transfer the claim to the railroad carrier (The Travelers Insurance Company) for processing. The Travelers Insurance Company will send the notice of benefits and other information required for the provider's records directly to the provider.

Charges for outpatient physical therapy should always be listed on a separate SSA-1490. Any charges for other clinic services require the completion of another SSA-1490.

Outpatient physical therapy furnished before the effective date of certification of the clinic is covered only if furnished by a physician or if incident to a physician's service. Therefore, services before the effective date of certification should be billed in the usual manner. Inclusive dates of service should not be used to report outpatient physical therapy services before and after the effective date of certification.

REQUEST FOR MEDICARE PAYMENT
MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT
 (See Instructions on Back—Type or Print Information)

Form Approved
 Budget Bureau No.
 72-RO730

PART I—PATIENT TO FILL IN ITEMS 1 THROUGH 6 ONLY

A	Copy from your HEALTH INSURANCE CARD (See example on back)	1 Name of patient Alma O. Blank	<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female
		2 Health insurance claim number 000-00-0000A	
3	Patient's street address 1098 None Street	City, State, ZIP code Anywhere, Maryland 21200	Telephone Number 869-9000
4	Describe the illness or injury for which you received treatment (Always fill in this item if your doctor does not complete Part II below)		Was your illness or injury connected with your employment? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5	If you have other health insurance or if your State Medical Assistance Agency will pay part of your medical expenses and you want information about this claim released to the Insurance Company or State Agency, upon request, give the following information.		
	Insuring organization or State agency name and address County Welfare Agency, 1694 Purl Street, Anywhere, Maryland 21200	Policy or Medical Assistance Number DPW-1006829	
6	I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.		
	Signature of patient (See instructions on reverse where patient is unable to sign) <i>Alma O. Blank</i>		Date signed Sept. 2, 1968

SIGN HERE *Alma O. Blank* *Sept. 2, 1968*

PART II—PHYSICIAN OR SUPPLIER TO FILL IN 7 THROUGH 14

7 A Date of each service	B Place of service (*See Codes below)	C Fully describe surgical or medical procedures and other services or supplies furnished for each date given	D Nature of illness or injury requiring services or supplies	E Charges (If related to unusual circumstances explain in 7C)	Leave Blank
1968					
09-02 to 09-07	NH	Daily physical therapy treatments (6) for early ambulation and mobilization of patient.	Fractured hip	\$ 60.00	
09-09 to 09-11	OL				
09-13 (Clinic)		Whirlpool baths (3)	" "	30.00	
09-17 and 09-19	"	" " (2)	" "	20.00	
09-27	"	" bath (1)	" "	10.00	
8 Name and address of physician or supplier (Number and street, city, State, ZIP code) Midtown Clinic, 123 Jot Street, Anywhere, Maryland 21200			Telephone No. 870-1500	9 Total charges \$ 120.00	
			Physician or supplier code 505052	10 Amount paid \$ 24.00	
				11 Any unpaid balance due \$ 96.00	
12 Assignment of patient's bill <input type="checkbox"/> I accept assignment <input type="checkbox"/> I do not accept assignment			13 Show name and address of facility where services were performed (If other than home or office visits) Pines Nursing Home, 501 Jack Street, Anywhere, Maryland 21200		
14 Signature of physician or supplier (A physician's signature certifies that physician's services were personally rendered by him or under his personal direction) <i>J. C. Jones, Administrator</i>			<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DDS Other degree — —	Date signed 10/1/68	

FORM SSA-1490 (1-68)

Department of Health, Education, and Welfare
 Social Security Administration

320.1 When to Submit Billing Form for Outpatient Physical Therapy Services.--An SSA-1490 should be submitted to the Part B carrier when the clinic furnishes outpatient physical therapy services, regardless of whether the deductible has or has not been met. Do not submit the SSA-1490, however, if the patient is **not** enrolled under Part B **or** workmen's compensation will pay the bill.

320.2 How to Complete the Request for Medicare Payment.---

Items 1 and 2: Patient Identification. Copy the patient's name and health insurance claim number exactly as they appear on the health insurance card. The number may also appear on an Explanation of Medicare Benefits notice or may be obtained from the social security district office if it is not known. Enter the patient's sex in the item following the number.

Item 3: Patient's Address. Enter the patient's complete permanent address including zip code. If a box number or "in care of" is in the address, be sure to include this. (The name and address of the extended care facility, nursing home, or hospital where a patient may have actually received services is shown in item 13.)

Item 4: Illness or Injury. Check yes or no to indicate whether the patient's illness or injury is related to his employment. (See § 245.) It is not necessary to show illness or injury in this item.

Item 5: Insuring Organization or State Agency. Welfare agencies or other health benefit insurers may ask the Medicare carrier for information about the claim. This item is the patient's authorization to release claims information. If the clinic does not wish medical information released to the organization named in this item, it should enter "no further release" in item 7C, following the description of services.

Item 6: Signature. The patient signs and dates the form. Ordinarily a single signed request will suffice for each outpatient physical therapy plan. If the clinic obtains the patient's signature on its own record (see § 240.2) enter the words "Contained in provider's record" in this item. The effective

period of such a signature should be for the anticipated period of treatment, but may not exceed 1 year. Some clinics may prefer to restrict the period to accommodate their own billing requirements.

If the claim is filed for the patient by another person, the person signing the form should enter the patient's name and write "By," sign his own name and address in this space, show his relationship to the patient, and explain why the patient cannot sign. (See § 241.)

The statement should be read to the patient who signs by mark. A signature by mark should be witnessed by a person who knows the patient. Enter the name and address of any person witnessing a signature by mark.

Item 7A: Date of Each Service. Each date of service should be shown. Inclusive dates can be used where the same service and charge applies throughout the inclusive period. Because of the deductible provision described in § 210, inclusive dates should not overlap September and October, December and January, or periods when the patient was not entitled. Also, inclusive dates should not overlap the period before the clinic was certified as a provider.

Item 7B: Place of Service. The place of service is indicated using the codes at the bottom of the page. For all except home or office visits, the name and address of the facility where the service was performed is stated in item 13. This includes hospitals, nursing homes, and extended care facilities only.

Item 7C: Description of Service. Furnish a precise description, in standard nomenclature, of the service being billed. Outpatient physical therapy charges should not be combined with the charges for any other type of service. Indicate the type of therapy furnished.

Item 7D: Nature of Illness. Enter the nature of the illness or injury in standard nomenclature.

Item 7E: Charges. The customary charge for each service should be entered. If there were any special circumstances explaining the charge, these should be described in 7C. Although interim reimbursement is on a charge basis, final settlement is on the basis of cost (see § 200).

Item 8: Identification of Physician or Supplier. Name, address, telephone number, and assigned code (provider) number.

Items 9, 10, 11: Total Charges, Amount Paid, and Any Unpaid Balance Due. Be sure to enter any payments which the patient has made in item 10. If the patient's payments exceed his liability, the carrier will refund the overpayment to the patient and deduct the overpayment from any amount otherwise due the clinic.

Item 12: Assignment. This item is not used in billing for outpatient physical therapy.

Item 13: Facility. For other than home or office visits, enter the name and address of the facility where services were performed, e.g., hospital, ECF, or nursing home.

Item 14: Signature. An authorized person should sign on behalf of the clinic and enter the date signed. The signature certifies that the plan of treatment has been established and is periodically reviewed and that the physician's certification and recertification (where appropriate) is on file. (See §§ 205ff.)


399. EXHIBITS

Exhibit 1. Health Insurance Cards and Claim Numbers.


Exhibit 2. Certificate of Social Insurance Award.

Exhibit 3. Temporary Notice of Eligibility.

HEALTH INSURANCE CARDS

Health Insurance	
SOCIAL SECURITY ACT	
NAME OF BENEFICIARY JANE Q. DOE	
CLAIM NUMBER 000-00-0000B	SEX FEMALE
IS ENTITLED TO	EFFECTIVE DATE
HOSPITAL INSURANCE	7-1-66
MEDICAL INSURANCE	7-1-66
SIGN HERE 	

Front

Health Insurance	
RAILROAD RETIREMENT BOARD	
NAME OF BENEFICIARY JOHN C. DOE	
CLAIM NUMBER A-000-00-0000	SEX MALE
IS ENTITLED TO	EFFECTIVE DATE
HOSPITAL INSURANCE	7-1-66
MEDICAL INSURANCE	7-1-66
SIGN HERE 	

Front

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical or health services under "Medicare."
3. Get in touch with your social security office if you have questions about your rights under "Medicare."
4. Your card is good wherever you live in the United States.

WARNING: Issued for the sole use of the holder designated hereon. Intentional misuse of this card is unlawful and will make the offender liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT.
IF FOUND DROP IN NEAREST U.S. MAIL BOX.

Return To: SOCIAL SECURITY ADMINISTRATION
Baltimore, Maryland 21235

FORM SSA-1966 (7-66)

Back

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical or health services under "Medicare".
3. Get in touch with your Railroad Retirement Board office if you have questions about your rights under "Medicare."
4. Your card is good wherever you live in the United States. For benefits in Canada, write to the Railroad Retirement Board.

WARNING: Issued for the sole use of the holder designated hereon. Intentional misuse of this card is unlawful and will make the offender liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT.
IF FOUND DROP IN NEAREST U.S. MAIL BOX.

Return to: RAILROAD RETIREMENT BOARD
844 Rush Street, Chicago, Illinois 60671

Form G-43 (2-66)

Back

HEALTH INSURANCE CLAIM NUMBERS

Most HI claim numbers are 9 digits with a letter or letter and numeral suffix; e.g., 000-00-0000B or B1. They may also be 6-or-9-digit numbers with lettered prefixes; e.g., A000000, A-000-00-0000; or WD-000000, WD-000-00-0000. Numbers with one or more letter prefixes identify Railroad Retirement Board annuitants.

Possible suffixes are:

A, B, B1, B2, B3, B4, B5, B6, or B9

C1, C2, C3, C4, C5, C6, C7, C8, or C9

D, D1, D2, D3, D4, D5, D6, or D7

E, E1, E2, or E3

F1, F2, F3, F4, F5, F6, F7, or F8

HB, HB1, HB2, HB3, HB4, HB5, HB6, or HB9

HC1, HC2, HC3, HC4, HC5, HC6, HC7, HC8, or HC9

J1, J2, J3, J4 (For subscripts "3" and "4" there can be no entitlement to hospital insurance benefits.)

K1, K2, K3, K4 (Supplementary medical insurance entitlement may exist for all J and K suffixes.)

M, M1, and T (Suffix letter "T" indicates entitlement to hospital and medical insurance; letters M and M1 indicate that the patient is eligible for supplementary medical insurance benefits but not for hospital insurance benefits.)

When the status of a beneficiary changes, it is possible for the suffix of his claim number to change.

DISTRICT OFFICE

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

CLAIM NUMBER

Certificate of Social Insurance Award

PAYMENT CENTER:

DATE:



THIS IS TO CERTIFY THAT THE PERSON(S) NAMED BELOW BECAME ENTITLED TO THE INSURANCE BENEFITS SHOWN, PAYABLE UNDER TITLE II OF THE SOCIAL SECURITY ACT.

NAME AND ADDRESS OF PAYEE AS THE CLAIMANT
OR AS REPRESENTATIVE OF THE CLAIMANT

DATE OF
ENTITLEMENT

MONTHLY
BENEFIT

AMOUNT OF
FIRST CHECK

TYPE OF BENEFIT:

The right to receive social security benefits carries with it certain responsibilities. They are explained in the enclosed booklet. Read this booklet carefully. Be sure that you understand clearly what you can expect by way of benefits, and what is to be expected of you.

NOTICE: If you believe that this determination is not correct, you may request that your case be reexamined. If you want this reconsideration, you must request it not later than 6 months from the date of this notice. You may make any such request through your social security office. If additional evidence is available, you should submit it with your request.

ROBERT M. BALL
COMMISSIONER OF SOCIAL SECURITY

FORM OA - 30 (3 - 68)

KEEP AS A PERMANENT RECORD—DO NOT DESTROY

EXHIBIT 3

TEMPORARY NOTICE OF ELIGIBILITY

District Office Address:

Date:

Dear :

Based on the information you have given to the Social Security Administration you will be eligible for hospital insurance benefits beginning (mo.) (yr.) and for supplementary medical insurance benefits beginning (mo.) (yr.). Your eligibility will continue for 60 days from the date shown at the top of this notice unless you are notified otherwise during the 60-day period.

To obtain medical services before you receive your card, show this letter to your hospital or doctor but keep the letter with you. This temporary notice of eligibility is to be used only by the person to whom it is addressed. Misuse is unlawful and will make the offender liable to a penalty.

This letter should be destroyed as soon as you receive your health insurance card or other notice concerning your eligibility.

Sincerely yours,

Robert M. Ball
Commissioner of Social Security

IMPORTANT

When services are provided on the basis of this notice, all bills or correspondence with an intermediary or the Social Security Administration should show the patient's social security claim number.

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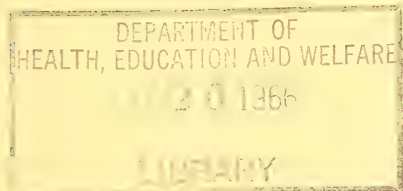
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HEALTH
INSURANCE
FOR THE AGED

HOSPITAL
MANUAL



U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

HIM-10 (6-66)

Health Insurance for the Aged

HOSPITAL MANUAL

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USING THE HOSPITAL MANUAL

Use It for Reference

The manual covers not only routine information for your day-to-day operations but tries to anticipate infrequent situations that could occur. Use it for reference.

Keep It Available

Pages are punched for any standard-size three-ring hardback binder. Keep it handy and ask for as many extra copies as you need.

Keep It Up-to-Date

Insert or replacement pages for additions and revisions will be furnished through your intermediary. Maintain a control on all manuals to assure immediate updating.

Use Chapter Subjects

A detailed index to facilitate locating of specific information will be sent later. The general subject listing for each chapter will help by giving designated section heads.

FOREWORD

This manual is designed for use by hospitals which will be billing for services furnished under the provisions of the Health Insurance for the Aged Act of 1965. It contains informational and procedural material the hospital will need to assist in prompt and efficient payment of claims and to answer questions which patients may ask about the program. This issuance should help to assure that the law is uniformly applied nationally without regard to where covered services are furnished. The hospital's intermediary will issue any necessary supplementary instructions on matters which concern the relationship between hospitals and intermediaries.

The manual does not have the effect of regulations, but a careful effort has been made to insure that the provisions of the law and proposed regulations are accurately reflected.

The procedures described in this manual have been devised to satisfy the administrative needs of the program with a minimum of inconvenience to beneficiaries, and to hospitals and their intermediaries. We believe that the vast majority of claims will lend themselves to simple, routine handling.

The manual is designed to accommodate new pages as further interpretations of the law and changes in procedures are made. Accordingly, revised sections, pages, or chapters will be issued as the need presents itself.

Your intermediary will answer any questions you may have about policies and procedures in the program. Hospitals dealing directly with the Social Security Administration may direct questions to the servicing social security district office for reply or refer them to the Bureau of Health Insurance Regional Representative.

us
ARTHUR E. HESS
Director, Bureau of Health Insurance

Chapter I

GENERAL INFORMATION ABOUT THE PROGRAM

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Chapter I

GENERAL INFORMATION ABOUT THE PROGRAM

100. INTRODUCTION

The Health Insurance for the Aged Act, Title XVIII of the Social Security Act, has made available to nearly every American 65 years of age and older a broad program of health insurance designed to assist the Nation's elderly to meet hospital, medical, and other health costs. The program includes two related health insurance programs—hospital insurance (Part A of the law) and voluntary supplementary medical insurance (Part B of the law).

The conduct of the program has been delegated by the Secretary of Health, Education, and Welfare, to the Commissioner of Social Security. Congress has provided substantial administrative roles for the States and for voluntary insurance organizations in recognition of their experience in the health care and insurance fields.

The law specifically prohibits the Federal Government from exercising supervision or control over the practice of medicine, the manner in which medical services are provided, and the administration or operation of medical facilities. The patient is free to choose any qualified institution, agency, or person offering him services. The responsibility for his treatment and the control of his care remains with his physician and the hospital or other facility or agency furnishing him services. The individual may keep or obtain any other health insurance he desires.

102. DISCRIMINATION PROHIBITED

Participating providers of services under the hospital insurance program, i.e., hospitals, extended care facilities, and home health agencies, must comply with the requirements of Title VI of the Civil Rights Act of 1964. Under the provisions of that Act a participating hospital is prohibited from making a distinction on the ground of race, color, or national origin in the admission and treatment of patients; the accommodations provided; the use of equipment and other facilities; and the assignment of personnel to provide services.

Title VI prohibits discrimination on the ground of race, color, or national origin in the selection by the hospital of physicians, surgeons, dentists, or other practitioners seeking the privilege of practicing in the hos-

pital, as well as of consultants, advisers, volunteers, and observers.

The Department of Health, Education, and Welfare is responsible for investigating complaints of noncompliance.

104. DISCLOSURE OF INFORMATION

Records and information acquired in the administration of the Social Security Act are confidential and may be disclosed only under the conditions prescribed in regulations or on the express authorization of the Commissioner of Social Security. The regulations of the Department of Health, Education, and Welfare regarding the confidentiality of records and information apply not only to governmental agencies, but also to public and private agencies participating in the administration of the program as well as those institutions, facilities, agencies, and persons providing services, and those furnishing services under arrangements with a provider of services. However, the medical records of a patient (other than those obtained from the Social Security Administration) are the property of the hospital and are not subject to these rules and regulations even though the patient receives benefits under this program. These records, however, may be subject to State or local laws or hospital rules governing disclosure, and are subject to the requirement of confidentiality in Standard A, page 21, *Conditions of Participation for Hospitals*.

Disclosure by a provider of records or information is permitted when necessary in connection with a claim under health insurance and for the proper performance of the duties of any officer or employee of a public or private agency, or organization which has entered into an agreement with the Social Security Administration to carry out the health insurance provisions of the law.

Program information furnished by a hospital to a State agency certifying providers in the health insurance program may, with the approval of the Department of Health, Education, and Welfare, be disclosed by the State agency to the State licensing authority if the information relates to the hospital's compliance or noncompliance with the licensure requirements.

Program information and records may not be disclosed to others not enumerated above except under the conditions prescribed by regulations.

110. HOSPITAL INSURANCE

This is the basic part of the health insurance program designed to help patients defray the expenses incurred by hospitalization and related care. In addition to inpatient hospital benefits, hospital insurance covers outpatient hospital diagnostic services, posthospital care in extended care facilities (such as skilled nursing homes), and in the patient's home by home health agencies. In providing these additional benefits, recognition was given to the need for continued treatment after hospitalization and the need to encourage the use of less expensive substitutes for inpatient hospital care. Program payment for services rendered to beneficiaries by providers (i.e., hospitals, extended care facilities, and home health agencies) may be made only to the provider, and is based on the reasonable cost of the covered services furnished.

110.1 Hospital Services Covered Under Hospital Insurance.—Hospital services covered under hospital insurance include inpatient hospital services and outpatient hospital diagnostic services. These benefits and the applicable deductibles, coinsurance, limitations, and exclusions are fully treated in chapter II of this manual. What follows in this section is a brief description of the other covered services under hospital insurance.

110.2 Posthospital Extended Care Services.—In each spell of illness (as defined in chapter II) payment may be made for the reasonable cost of up to 100 days of posthospital extended care services, except that the patient is responsible for \$5 per day after the 20th day. The beneficiary must have been a hospital inpatient for at least 3 consecutive calendar days and be admitted to the extended care facility within 14 calendar days after the date of hospital discharge. (Benefits for posthospital extended care are payable for services furnished on or after January 1, 1967. The hospital discharge must occur after June 30, 1966, or on or after the first day of the month in which the beneficiary attains age 65, whichever is later.)

An extended care facility is one which provides skilled nursing care and related services for patients who require medical or nursing care; or rehabilitation services for injured, disabled, or sick persons. It may be either a separate institution (e.g., nursing home) or a part of an institution (e.g., a convalescent wing of a hospital). It must be licensed or approved under State or local law, meet the health and safety conditions prescribed by the Secretary of Health, Education, and Welfare, and have a written transfer agreement with one or more participating hospitals providing for the transfer of patients between the hospital and the

facility, and for the interchange of medical and other information. If an otherwise qualified extended care facility has attempted in good faith but without success, to enter into a transfer agreement, this requirement may be waived by the State agency. A facility which is primarily for the care and treatment of mental disease or tuberculosis is excluded from the definition of extended care facility.

Extended care services include room and board; skilled nursing care by or under the supervision of a registered nurse; physical, occupational, or speech therapy; medical social services; and other services ordinarily furnished by the facility. No payment may be made for custodial care or for items or services which would not be covered in a hospital.

The services of residents-in-training and interns under an approved teaching program of a hospital with which the facility has a transfer agreement and other diagnostic and therapeutic services furnished by such a hospital are covered, but only if billed through the extended care facility.

110.3 Posthospital Home Health Services.—Home health services under hospital insurance include up to 100 home health visits furnished a patient within 1 year of his most recent discharge from a hospital of which he was an inpatient for at least 3 consecutive calendar days. If, after his hospitalization, he had a covered stay in an extended care facility, the 1 year during which the patient may receive home health services begins with the discharge from the extended care facility. A plan of treatment must be established within 14 days after the hospital or extended care facility discharge. Home health services are provided also under supplementary medical insurance. (For the latter see § 115.)

The patient receiving posthospital home health services must be under the care of a physician who must establish and periodically review the plan for his patient's care. To be covered, the services must be furnished after the beginning of one spell of illness and before the beginning of the next; the services must be required by a condition for which the patient required inpatient hospital services or extended care services; and the patient be confined to his home. Discharge from the period of hospitalization required for home health services must occur after June 30, 1966, or on or after the first day of the month in which the patient attains age 65, whichever is later.

Home health services are services provided by a home health agency or by others under arrangements with such an agency. A home health agency is a public agency or private organization licensed or approved under State or local law, which is primarily engaged in providing skilled nursing and other therapeutic services. Examples of home health agencies are visiting nurse associations, official health agencies, and hospital-

based home care programs. To participate in the health insurance program a home health agency must meet certain other requirements included in the law as well as health and safety conditions prescribed by the Secretary of Health, Education, and Welfare. It may not qualify under hospital insurance, however, if it is primarily engaged in the treatment of mental diseases.

These services are usually furnished in the patient's home or other place of residence. However, outpatient services in a hospital, extended care facility, or rehabilitation center are covered home health services, if arranged for by a home health agency, when equipment is required that cannot be made available in the patient's home.

Covered home health services include part-time nursing care by or under the supervision of a registered professional nurse; physical, occupational, or speech therapy; medical social services; certain services of a home health aide; medical supplies (other than drugs and biologicals); and the use of medical appliances. The cost of housekeepers, food service arrangements, and transportation to outpatient facilities is excluded.

The services of an intern or resident-in-training under an approved teaching program of a hospital are covered if the agency and hospital are affiliated or under common control and the agency bills for the services.

115. SUPPLEMENTARY MEDICAL INSURANCE

The voluntary medical insurance plan is designed to supplement the basic hospital insurance coverage. It provides coverage for the expense of physicians' services, including surgery, consultation, and home, office, and institutional calls. (Physician services do not include the services provided by an intern or resident-in-training under an approved teaching program.)

Medical insurance also covers home health services for up to 100 visits during the calendar year (in addition to the visits covered under hospital insurance) but without the requirement of prior inpatient care. The plan also provides coverage for services and supplies (including drugs and biologicals which cannot be self-administered) furnished incident to a physician's professional service of a type usually furnished in a physician's office and usually rendered without charge or included in the physician's bill.

See §§ 240 ff., "Hospital Services Under Supplementary Medical Insurance" for a fuller discussion, including additional items and services included in this part of the program for which providers may be reimbursed, and for the medical insurance deductible and coinsurance.

The amount of payment for covered services rendered by other than providers under the medical insurance plan is determined by the designated medical insurance

intermediary on a **reasonable charge** basis. Payment is made to the beneficiary unless the physician or other supplier of services has accepted an assignment, in which case, payment is made to the physician or supplier. In determining the reasonableness of charges, Part B carriers take into consideration the customary charges of the physician (or other person rendering the service) as well as the prevailing charges which are generally made in the locality for similar services. A charge is **not** reasonable if it is higher than the charge applicable for a comparable service and under comparable circumstances to the intermediary's own policyholders or subscribers.

Reimbursement to a provider for services covered by the medical insurance plan is made by the provider's (Part A) fiscal intermediary on a reasonable cost basis. In cases where the provider has elected to deal directly with the Government, the provider will be reimbursed by the Social Security Administration for services covered by medical insurance.

Payment for the services of provider-based physicians (other than interns and residents-in-training) rendered to individual beneficiaries is made by the medical insurance (Part B) carrier designated to make payment for physicians' services.

120. ENTITLEMENT TO HOSPITAL INSURANCE

A. An individual is **automatically** entitled to hospital insurance beginning with the first day of the month he attains age 65 if he has applied for and been determined to be entitled to monthly social security benefits (although he may not actually be receiving benefit payments; e.g., he has not retired). Automatic entitlement also extends to qualified beneficiaries under the Railroad Retirement Act. (For social security purposes, a person attains age 65 on the day before his 65th birthday. Example: If birth date is August 1, attainment date is July 31, and health insurance entitlement date is July 1.)

A social security applicant who applies for monthly benefits after the month he reaches age 65 is entitled to retroactive hospital insurance benefits beginning with the first month in which he had attained age 65 and met all the requirements for monthly benefits, but not for more than 12 months before the month in which he filed his application.

Entitlement to hospital insurance benefits ends with the month the individual ceases to be entitled to social security monthly benefits or ceases to be a qualified railroad beneficiary (for example, a woman whose wife's benefits are terminated by divorce). A person who ceases to be a social security or railroad retirement beneficiary but who meets the requirements of the special transitional provision described below may reinstate his hospital insurance by filing a proper application under the transitional provision.

Hospital insurance coverage continues for the month of death, although no monthly cash benefits are payable for that month.

B. A special **transitional** provision in the law permits persons 65 years of age and over, who cannot qualify for monthly social security or railroad retirement benefits, to obtain hospital insurance upon filing application. Such an individual must be a resident of the United States and either a citizen or an alien lawfully admitted for permanent residence who has resided in the United States continuously for 5 years. He may not be an active or retired Federal employee (or spouse of one) who is or could have been covered by the Federal Employees Health Benefit Act of 1959. He may not be a member of a communist organization nor have been convicted of a crime against the security of the United States.

For coverage under the transitional provision, a person attaining age 65 after 1967 must have three quarters of coverage for each year elapsing between 1965 and the year in which he attains age 65.

Hospital insurance under the transitional provision can also be retroactive for as many as 12 months before the month of application, provided the individual meets all the other requirements during the period of retroactivity.

122. ENTITLEMENT TO SUPPLEMENTARY MEDICAL INSURANCE

A. **Enrollment.**—To obtain supplementary medical insurance coverage an individual must voluntarily enroll in the plan and pay the required premiums. He is eligible to enroll if he is entitled to hospital insurance benefits or is 65 years of age and otherwise meets the requirements for hospital insurance coverage under the transitional provision of the law. Active or retired Federal employees and their spouses are eligible to enroll whether or not covered under the Federal Employees Health Benefit Act. (For social security purposes an individual attains age 65 on the day before his 65th birthday.)

By agreement States may enroll in the supplementary medical insurance plan eligible individuals who are receiving money payments under certain public assistance programs. Such persons who are entitled to monthly social security or railroad retirement benefits may be included at the option of the State.

B. **Enrollment Periods.**—Enrollment is possible only during specified enrollment periods.

1. During the **initial general enrollment period** an opportunity to enroll was afforded to all eligible persons age 65 and over before March 1, 1966. This enrollment period ended May 31, 1966. (An eligible individual who for good cause failed to enroll before June 1, 1966, may enroll before October 1, 1966.)

2. For persons first eligible on or after March 1, 1966, the **initial enrollment period** is 7 months. It begins 3 calendar months before and ends 3 calendar months after the month in which the individual first meets all enrollment requirements.

3. **General enrollment periods** occur October 1 through December 31 of each odd-numbered year beginning with 1967. Those who failed to enroll during their initial enrollment periods and those whose enrollment has terminated may enroll in these periods.

4. **States which desire to enroll eligible individuals receiving public assistance** must request coverage before January 1968, and enter into an agreement with the Government.

An individual who fails to enroll for medical insurance within the 3-year period after the close of his initial enrollment period may not enroll thereafter.

An individual whose enrollment has terminated may re-enroll only once—in a general enrollment period which begins within 3 years after the termination of his prior enrollment.

Payment may be made for covered services if the individual was enrolled at the time the services were furnished, even though at the time the request for payment is filed with the intermediary his enrollment had been terminated.

122.1 Premiums.—Initially, the premium is \$3 per month. The law permits the Secretary of Health, Education, and Welfare to adjust the premium amount if medical costs rise. No increase in the premium is permitted before 1968, and increases thereafter can be no oftener than every 2 years. To take into account the higher cost of insuring older individuals, premiums payable by a person who enrolls after the first enrollment period open to him, or who re-enrolls after his initial enrollment was terminated, are increased by 10 percent for each year he could have been but was not enrolled.

A grace period has been provided for payment of premiums. This period extends for 2 calendar months after the month in which the premium is due.

Social security and railroad retirement beneficiaries and civil service annuitants (except those enrolled by the State as public assistance recipients) who elect to enroll will have the premiums withheld from their monthly checks. The State pays the premiums for the public assistance recipients it enrolls.

Other enrollees must make premium payments directly to the Social Security Administration. Enrollees who make direct premium payment will generally be billed quarterly. However, State or local government organizations, employers, unions, or other organizations may under certain conditions pay premiums for their members as a group.

122.2 Beginning of Coverage

A. Enrollment during the initial general enrollment period—coverage begins July 1, 1966.

B. Enrollment during an entitled individual's initial enrollment period—coverage begins:

1. 1st day of the month in which the individual becomes age 65, if he enrolls **before** the month that he becomes 65.

2. 1st day of the month following the month that he becomes age 65, if he enrolls **in** the month that he becomes 65.

3. 1st day of the 2d month after the month of enrollment, if he enrolls in the month **after** he becomes age 65.

4. 1st day of the 3d month after the month of enrollment, if he enrolls **more than 1 month after** the month in which he became age 65. (However, individuals who become age 65 in March 1966, and enroll in May 1966, will have coverage effective July 1, 1966.)

C. Enrollment during one of the general enrollment periods—coverage begins the following July 1st.

D. Enrollment by a State of its welfare recipients—coverage begins on the latest of the following but not later than January 1, 1968:

1. July 1, 1966;
2. 1st day of the 3d month after the month of the agreement with the State;
3. 1st day of the first month in which the individual is both eligible and a member of the group;
4. The date specified in the agreement.

122.3 End of Coverage

A. An individual whose medical insurance premiums are being deducted may notify the Social Security Administration in writing during a general enrollment period that he no longer wants medical insurance. His coverage period will be terminated with the close of the year in which his notice is submitted.

B. Enrollment under medical insurance is terminated because of nonpayment of premiums. Termination is effective with the end of the grace period provided for payment of premiums.

C. If an individual is enrolled under a Federal-State agreement, his coverage under the agreement ends on whichever of the following first occurs:

1. The end of the month in which he becomes ineligible (as determined by the State) for welfare money payments; or
2. The end of the month before the first month for which he becomes entitled to monthly social security or railroad retirement benefits, unless the State exercises its option to enroll such welfare recipients; or
3. The month in which the agreement terminates.

If an individual's coverage under a Federal-State enrollment agreement is terminated, his coverage con-

tinues without interruption if he is a social security or railroad retirement beneficiary or continues payment of premiums.

D. An individual will have coverage through the month in which he dies.

130. FEDERAL GOVERNMENT ADMINISTRATION OF THE HEALTH INSURANCE PROGRAM

The Department of Health, Education, and Welfare has been given overall responsibility for administration of the hospital insurance and voluntary supplementary medical insurance programs. Three major agencies of the Department—the Social Security Administration, Public Health Service, and Welfare Administration—are involved.

130.1 The Social Security Administration has the responsibility for policy formulation and the general management and operational aspects of the program. Briefly, these include: determination of the individual's entitlement to benefits and the nature and duration of services for which benefits may be paid; establishment, maintenance, and administration of agreements with State agencies, providers of services and intermediaries; in consultation with the Public Health Service and the Welfare Administration, the formulation of major policies regarding conditions of participation for providers; the development and maintenance of statistical research and actuarial programs; and the general financial management of the program. The Administration also makes determinations of reasonable costs and amounts to be paid to providers who have elected to deal directly with the Government.

130.2 The Public Health Service has the principal responsibility for the professional health aspects of the program. These include: professional consultation and recommendation to the Social Security Administration in development of health and safety, and other guidelines for determining whether providers of services meet the conditions for participation under the program; consultation and advice to State agencies concerning the application of standards for providers, and in the coordination of program activities with other health services and activities in the State; and activities necessary in studying the utilization of hospital and other medical care services under the program.

130.3 The Welfare Administration has the primary role in hospital and medical insurance program planning, coordination, and evaluation in matters that affect other federally aided assistance programs; in assisting State agencies to achieve a coordinated approach with other medical care plans under the Social Security Act; and in all aspects of program administration affecting public welfare agencies.

131. ADVISORY GROUPS

The law provides for the appointment of two non-governmental advisory groups to assist the Secretary.

131.1 The Health Insurance Benefits Advisory Council, consisting of persons outstanding in hospital, medical, and other health activities, and at least one representative of the general public, advises the Secretary on general policy in administering the program and in the formulation of regulations. The Secretary must consult with the Council in determining conditions of participation for hospitals and other providers of services in addition to the requirements specifically enumerated in the law.

131.2 The National Medical Review Committee is to be selected from people who are representative of professional organizations and associations in the field of medicine and other individuals who are outstanding in the field of medicine or in related fields. At least one member will represent the general public and a majority of the committee are to be physicians. The committee studies the utilization of hospital and other medical services under the program and makes any recommendations to the Secretary and to Congress that it considers appropriate.

132. STATE AGENCIES

The States are accorded important administrative functions to the extent that each is willing and able to undertake them by agreement with the Secretary.

A. Certifications are made by State agencies to the Department of Health, Education, and Welfare indicating whether hospitals, extended care facilities, home health agencies, and independent laboratories meet and continue to meet their respective conditions of participation. This function is intended to be a natural adjunct to ongoing State activities, such as licensing of health facilities and other standard setting activities.

B. Consultation services are rendered by State agencies if their agreements provide for it. Consultation with hospitals, extended care facilities, and home health agencies that need and request assistance to meet the conditions of participation is an integral part of the certification process.

C. Coordination by the State relates its activities in the performance of its functions under the program to the various other programs in the State that have to do with payment for health care, quality of care, and distribution of health facilities. Coordination of such activities is designed effectively and economically to utilize existing State facilities and trained personnel and to prevent duplication of effort.

D. State Agency as a Medical Insurance Intermediary.—Where a State enters into an agreement with the Government to pay the medical insurance premium on behalf of its aged welfare recipients, as

explained in § 122B of this chapter, the agreement may provide for a designated State agency to serve as an intermediary on behalf of its welfare recipients.

135. HOSPITAL INSURANCE INTERMEDIARIES

Under the hospital insurance plan, groups or associations of providers, on behalf of their members, may nominate a national, State, or other public or private agency, or organization to serve as intermediary in the claims process. A member of an association is free, however, to receive payment from an approved intermediary other than its association's nominee, if agreeable to the Social Security Administration and to the intermediary selected. A provider may deal directly with the Social Security Administration.

The law permits the Administration to enter into an agreement with a nominated organization if it finds this to be consistent with effective and efficient administration of the hospital insurance program. The intermediary makes payments to providers for covered items and services on the basis of reasonable cost determinations and assists in the application of safeguards against unnecessary utilization of covered services. The agreement may also call for furnishing consultative services to assist providers to establish and maintain necessary fiscal records and otherwise qualify as providers of services; serving as a center for communicating with providers; and making audits of provider records.

Generally speaking, the Social Security Administration will utilize the services of the hospital insurance intermediary in making payments for hospital and other provider services under medical insurance.

137. MEDICAL INSURANCE CARRIERS

The law requires the Secretary to enter into contracts with carriers selected to serve as intermediaries for the performance of specified administrative functions under the medical insurance program. The principal function of these carriers is to determine whether physicians' charges are reasonable and to make payment. Section 122B of this chapter explains the conditions under which a State agency may act as a supplementary medical insurance intermediary.

140. FINANCING HOSPITAL INSURANCE PROGRAM

The hospital insurance program is financed through separate payroll contributions paid by employees, employers, and self-employed persons. The proceeds are earmarked for the Federal Hospital Insurance Trust Fund to keep them separate from other social security contributions. The law permits their use only for the payment of hospital insurance benefits and administrative expenses. The cost of providing hospital insurance benefits to persons who are not social security

or railroad retirement beneficiaries is met by appropriations to the Federal Hospital Insurance Trust Fund from general revenues.

142. FINANCING SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

The supplementary medical insurance plan is financed by the monthly premiums of those who en-

roll under the plan, matched by an equal contribution from general revenues. All premiums and Government contributions for this plan are placed in a separate fund known as the Federal Supplementary Medical Insurance Trust Fund. This fund is devoted exclusively to the payment of medical insurance benefits and administrative expenses.

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COVERAGE OF HOSPITAL SERVICES

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Chapter II

COVERAGE OF HOSPITAL SERVICES

Definitions

200. HOSPITAL DEFINED

A **Hospital (Other Than Tuberculosis or Psychiatric)** is an institution which:

- a. is primarily engaged in providing to inpatients, by or under the supervision of physicians,
 - (1) diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or
 - (2) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;
- b. maintains clinical records on all patients;
- c. has bylaws in effect concerning its staff of physicians;
- d. requires that every patient must be under the care of a physician;
- e. provides 24-hour nursing service by or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;
- f. has in effect a hospital utilization review plan;
- g. is licensed or is approved by the State or local licensing agency as meeting the standards established for such licensing;
- h. meets other health and safety requirements of the Secretary of Health, Education, and Welfare. (These additional requirements may not be higher than comparable ones prescribed for accreditation by the Joint Commission on Accreditation of Hospitals with certain exceptions specified in the law.)
- i. is not primarily for the care and treatment of mental diseases or tuberculosis.

201. PARTICIPATING HOSPITAL

Payment may ordinarily be made only to a participating hospital for covered services furnished by the hospital or by others under arrangements with the hospital. A participating hospital is an institution approved by the Social Security Administration which has entered into an agreement with the Administration not to charge any patient or other person for covered items and services, except deductibles and coinsurance amounts; to return any money incorrectly collected; and to provide services on a nondiscriminatory basis

in compliance with Title VI of the Civil Rights Act of 1964.

202. HOSPITAL EMERGENCY SERVICES

A nonparticipating hospital is one which does not have an agreement to participate whether or not it meets the other requirements for participation. Such a hospital, however, may receive payment for inpatient hospital services or outpatient hospital diagnostic services furnished by it, or by others under arrangements with it under the following conditions:

- a. the services **must** be emergency services;
- b. they must be covered services under **hospital** insurance;
- c. the hospital must meet the requirements of the definition of a hospital, psychiatric hospital, or tuberculosis hospital, except for the utilization review plan and the health and safety conditions prescribed by the Secretary; and
- d. it must agree **on an individual case basis** not to charge any patient or other person for items or services covered by hospital insurance except deductibles and coinsurance amounts; and return any money incorrectly collected.

Payment for emergency inpatient hospital services and outpatient hospital diagnostic services will be made to the same extent that payment would be made if a participation agreement were in effect. Coverage of services continues only as long as the emergency continues.

Emergency services outside the United States are covered under limited conditions arising ordinarily only in border areas. Payment for emergency inpatient hospital services furnished outside the United States may be made if the emergency occurred in the United States and the foreign hospital was more readily accessible than the nearest U.S. hospital which could treat the condition.

Procedures for payment of claims for emergency services are being developed. They will require that the hospital furnish a full statement of the circumstances and medical necessity, and other information pertinent to a determination that the services furnished were emergency services.

203. TUBERCULOSIS HOSPITAL

A tuberculosis hospital is an institution which is primarily engaged in providing by or under the supervision of a physician, medical services for the diagnosis and treatment of tuberculosis. To qualify as a tuberculosis hospital, it must be accredited by the Joint Commission on Accreditation of Hospitals, have in effect a utilization review plan, and meet additional staffing and medical record requirements. (See "Conditions of Participation for Hospitals.")

204. PSYCHIATRIC HOSPITAL

A psychiatric hospital is an institution which is primarily engaged in providing by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons. To qualify as a psychiatric hospital, it must be accredited by the Joint Commission on Accreditation of Hospitals, have in effect a utilization review plan and meet the additional staffing and medical record requirements. (See "Conditions of Participation for Hospitals.")

205. PART OF TUBERCULOSIS OR PSYCHIATRIC INSTITUTION AS A TUBERCULOSIS OR PSYCHIATRIC HOSPITAL

A distinct part of a tuberculosis or psychiatric institution can be considered a tuberculosis or psychiatric hospital if it meets the conditions of participation even though the institution of which it is a part does not. If the distinct part meets requirements equivalent to the accreditation requirements of the JCAH, it can qualify under the program even though the institution itself is not accredited.

There is no provision for a psychiatric or tuberculosis wing of a general hospital to be certified as a psychiatric or tuberculosis hospital "distinct part." The distinct part provisions apply only to psychiatric and tuberculosis institutions and not to general hospitals.

206. CHRISTIAN SCIENCE SANATORIUM

A **Christian Science Sanatorium** operated or listed and certified by the First Church of Christ, Scientist, Boston, Mass., may qualify as both a **hospital** and **extended care facility**. Inpatient care in such an institution will begin or prolong a "spell of illness." (See § 215.)

207. UNDER ARRANGEMENTS

A hospital may make arrangements with others to furnish covered items or services. When such arrangements are made, receipt of payment by the hospital for the services (whether it bills in its own right or on behalf of those furnishing the services) must relieve the beneficiary or any other person of further liability.

There are additional special requirements on furnishing items and services under arrangements. These depend on the type of hospital service involved:

- a. For inpatient hospital services, see §§ 210 ff.
- b. For outpatient hospital diagnostic services, see §§ 230.2 and 232.
- c. For hospital services under medical insurance, see §§ 240 ff.

Inpatient Hospital Services

210. COVERED INPATIENT HOSPITAL SERVICES

Patients covered under hospital insurance are entitled to have payment made on their behalf on a reasonable cost basis for inpatient hospital services. (If a patient receives items or services in excess of, or more expensive than, those for which payment can be made, payment will be made only for the reasonable cost of the covered items or services. This provision applies not only to inpatient services but to all hospital services under Parts A and B of the program.)

The following inpatient hospital services (including psychiatric and tuberculosis hospital services) are covered:

210.1 Bed and Board.—Hospital insurance will pay for "semiprivate" accommodations (two-, three-, or four-bed accommodations) unless a private room is medically necessary.

A. Private rooms (or other accommodations more expensive than semiprivate) will ordinarily be considered medically necessary only when the patient's condition requires him to be isolated for his own health or that of others.

The term isolation can apply to the necessary conditions for the treatment of a number of physical and mental impairments. These include communicable diseases which in the judgment of the physician require isolation of the patient for certain periods. Privacy may also be necessary for patients whose symptoms or treatment are likely to alarm or disturb others in the same room.

Payment will also be made for the use of intensive care facilities where medically indicated.

B. When accommodations **more expensive** than semiprivate are furnished for reasons other than medical necessity, e.g., the patient's comfort, payment by the program will be limited to the cost of semiprivate accommodations. The hospital may not charge the patient more than the difference between the customary charges for the accommodations furnished and the customary charges for semiprivate accommodations at the most prevalent rate of the time of admission. See C. below for definition of "customary charges."

C. When accommodations **less expensive** than semiprivate are furnished at the patient's request or for a reason determined to be consistent with the purposes of the health insurance program, payment may be made for the reasonable cost of the accommodations

furnished. It is considered to be consistent with the program's purpose to furnish bed and board in less expensive accommodations where semiprivate accommodations are not available. The patient must then be moved to semiprivate accommodations when they become available.

It will not be considered consistent with the purposes of the law to assign a patient ward accommodations on the basis of his social or economic status, his national origin, race, or religion, his entitlement to have payment made under the Health Insurance for the Aged Act, or any other discriminatory reason when the patient has not requested such assignment.

In some cases, a patient may be placed in accommodations less expensive than semiprivate neither at his request nor for a reason consistent with the program's purposes. In determining the payment to be made, the reasonable cost of semiprivate accommodations will be reduced by the difference between the institution's customary charges for semiprivate accommodations at the most prevalent rate at the time of admission and for the accommodations furnished. ("Customary charges" means amounts which the hospital is uniformly charging patients currently for specific services and accommodations, with specified and limited exceptions, e.g., a lower charge as a fringe benefit to employees of a hospital and their close relatives.)

D. Payment may be made to hospitals which have only ward accommodations or only private accommodations on the basis of the reasonable cost of the accommodations furnished.

210.2 Nursing and Other Services.—Nursing and other related services, use of hospital facilities, and medical social services ordinarily furnished by the hospital for the care and treatment of inpatients.

NOTE: The services of a private duty nurse or other private duty attendant are not covered.

210.3 Drugs, Supplies, Appliances.—Drugs, biologicals, supplies, appliances, and equipment for use in the hospital, which are ordinarily furnished by the hospital for the care and treatment of inpatients.

A. **Drugs and biologicals** are covered if included (or approved for inclusion) in the United States Pharmacopoeia, the National Formulary, or the United States Homeopathic Pharmacopoeia, or in New Drugs or Accepted Dental Remedies (except for those unfavorably evaluated). Those drugs and biologicals approved by the pharmacy and drug therapeutics or equivalent committee of the medical staff of the hospital furnishing them for use in the hospital are also covered.

Combination drugs are covered if all of the active ingredients, i.e., the individual drugs constituting the

combination, are listed or approved for listing in any of the compendia named. Combination drugs approved by the pharmacy and therapeutics or equivalent committee for use in the hospital are covered.

B. **Supplies and appliances** are covered as inpatient hospital services only if they are a necessary part of the inpatient hospital services the patient receives. For example, the use of a wheelchair, crutches, or prosthetic appliances by an inpatient is covered. The cost of such an appliance is not covered as an inpatient hospital service when furnished to a patient to be used by him **only after his discharge**. The cost of modifying or altering an appliance after discharge is also not covered.

210.4 Other Diagnostic or Therapeutic Items or Services.—Other diagnostic or therapeutic items or services ordinarily furnished patients by hospitals or by others under arrangements with hospitals. Covered under this provision are prosthetic devices which replace internal body organs, and items such as splints or casts which may remain on the patient after his discharge from the hospital.

Diagnostic x-ray, or anatomical or clinical pathology services furnished to an inpatient by an independent laboratory under arrangements with the hospital are reimbursable under hospital insurance provided the laboratory:

- a. is licensed under State or applicable local law or is approved by the appropriate licensing agency; or
- b. if there is no State licensure law, is under direct supervision of a pathologist on a full-time or regular part-time basis; or
- c. is approved to provide these services for the supplementary medical insurance program. (See § 240.2.)

210.5 Services of Intern or Resident-in-Training.—Hospital insurance covers the reasonable cost of the services of an intern or resident-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association. In the case of services of an intern or resident-in-training in the field of dentistry in a hospital or osteopathic hospital, the teaching program must have the approval of the Council on Dental Education of the American Dental Association. **The medical and surgical services of a physician, resident, or intern are otherwise excluded under hospital insurance.**

210.6 Special Limitations on Services in Tuberculosis or Psychiatric Hospitals

A. **Inpatient Tuberculosis Hospital Service Restriction.**—Payment may be made for only those tuberculosis hospital inpatient services furnished when

the patient was receiving treatment which could reasonably be expected to improve his condition or render it noncommunicable.

B. Inpatient Psychiatric Hospital Service Restriction.—Payment may be made for only those psychiatric hospital inpatient services furnished when the patient was receiving intensive treatment; or for services which were necessary for a diagnostic study or equivalent services for which admission was required.

Duration of Covered Inpatient Services

215. SPELL OF ILLNESS DEFINED

A spell of illness is a period of consecutive days that begins with the first day (not included in a previous spell of illness) on which a patient is furnished inpatient hospital or extended care services by a qualified provider in a month for which the patient is entitled to hospital insurance benefits. A qualified hospital (including a psychiatric or tuberculosis hospital) or extended care facility is one that has been certified as meeting all the requirements of the definition of such an institution. A hospital which meets the requirements in § 202 is a qualified hospital for purposes of beginning a spell of illness when it furnishes the patient covered inpatient emergency services. **Thus, generally, the spell of illness begins when covered inpatient services are initially furnished to an entitled individual.**

The spell of illness ends with the close of a period of 60 consecutive days during which the patient was neither an inpatient of a hospital nor an inpatient of an extended care facility. *It is important to note that for purposes of continuing a spell of illness, the hospital or extended care facility in which the stay occurs need not meet all of the requirements that are necessary for starting a spell of illness.*

Inpatient services will prolong the beneficiary's spell of illness if the hospital meets the initial requirement of the definitions in §§ 200, 203, and 204. That is, it is primarily engaged in providing, by or under the supervision of physician(s), to inpatients (1) diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for injured, disabled, or sick persons; or (2) psychiatric services for the diagnosis and treatment of mentally ill persons; or (3) medical services for the diagnosis and treatment of tuberculosis.

Similarly, inpatient services in an extended care facility will prolong a beneficiary's spell of illness if the facility (including one primarily for the care and treatment of mental diseases or tuberculosis) meets at least the requirement that it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or

rehabilitation services for injured, disabled, or sick persons.

An individual may be discharged from and readmitted to a hospital or extended care facility several times during a spell of illness and still be in the same spell if 60 days have not elapsed between discharge and readmission. The stay need not be for related physical or mental conditions.

As long as a person continues to be entitled to hospital insurance, there is no limit to the number of spells of illness he may have.

Example 1: X was born August 9, 1902. On July 28, 1967, X entered a participating general hospital. After he had been in the hospital for 2 weeks X was discharged on August 11, 1967. On his doctor's orders X entered a participating nursing home on August 15, 1967, and remained there until his discharge on October 27, 1967. He had no further inpatient stays in 1967. X's spell of illness began on August 1, 1967, the first day of the month he attained age 65 and was entitled to hospital insurance. The spell of illness ended December 26, 1967, 60 days after his last discharge.

Example 2: Y, over age 65, entered a participating general hospital on July 28, 1968, for treatment of a heart condition. He was discharged on August 11, 1968. On August 20, 1968, Y entered a **nonparticipating nursing home**, which provided primarily skilled nursing care and related services. Y remained in this facility until his discharge on October 27, 1968. On December 25, 1968, Y was again admitted to a participating hospital because of injuries suffered in an accident. He was discharged on January 13, 1969, and had no further inpatient stays in 1969. Y's spell of illness began on July 28, 1968. His stay in the nursing home began less than 60 days after his hospital discharge and the spell was continued even though the stay was not covered. The subsequent hospital stay began less than 60 days after the nursing home discharge and continued the spell of illness, although the condition treated was unrelated to his prior stays. The spell ended on March 14, 1969.

216. INPATIENT HOSPITAL BENEFIT DAYS

A patient having hospital insurance coverage is entitled to have payment made on his behalf for up to **90 days** of covered inpatient hospital services in each spell of illness. (For coinsurance provision, see § 225.)

217. INPATIENT PSYCHIATRIC AND TUBERCULOSIS RESTRICTION

If an individual is in a hospital which meets the definition of a psychiatric or tuberculosis hospital on the first day of his entitlement to hospital insurance the number of inpatient benefit days in his first spell of illness is subject to reduction. The days on which

he was an inpatient of a psychiatric or tuberculosis hospital in the 90-day period immediately before his first day of entitlement, must be subtracted from the 90 days of inpatient hospital services for which he would otherwise be eligible in his first spell of illness. This provision does not apply to tuberculosis or psychiatric services in a general hospital. (See § 225 for effect on coinsurance provision.)

218. INPATIENT PSYCHIATRIC HOSPITAL SERVICES—LIFETIME LIMITATION

Payment may not be made for more than a total of 190 days of inpatient psychiatric hospital services during the patient's lifetime. **The limitation applies only to services furnished in a psychiatric hospital.** The period spent in a psychiatric hospital prior to entitlement does not count against the patient's lifetime limitation, even though pre-entitlement days may have been counted against the 90 days of eligibility in the first spell of illness.

219. INPATIENT SERVICES COUNTING TOWARD MAXIMUMS

Inpatient hospital (including psychiatric and tuberculosis hospitals) services count toward the maximum number of benefit days payable per spell of illness only if:

- (1) payment for the services is made, or
- (2) payment for the services would be made if a request for payment were properly filed and if a physician certified that the services were necessary.

Similarly, inpatient psychiatric hospital services count toward the 190-day lifetime limitation on inpatient psychiatric hospital services only if these conditions are met.

Inpatient Deductibles and Coinsurance

220. DEDUCTIBLE

The patient is responsible for a deductible amount of \$40 for inpatient hospital services in each spell of illness. This amount is subject to change, but not before 1969. Each year beginning in 1968, the Secretary of Health, Education, and Welfare will determine the amount of the deductible for the following year.

If the hospital's customary charges on an initial stay in a spell of illness are more than the actual charges to the patient, but neither exceeds the \$40 inpatient deductible, the customary charge will be used in computing the amount of the deductible met. (See § 210.1C for definition of customary charges.)

A reduction in benefit days resulting from confinement in a tuberculosis or psychiatric hospital on and immediately preceding the date of entitlement (see § 217) does not affect the amount of the deductible for which the patient is responsible. The deductible amount remains at \$40.

222. WHOLE BLOOD DEDUCTIBLE

A. Whole Blood Defined.—For purposes of the whole blood deductible, whole blood is human blood from which none of the liquid or cellular components have been removed. Components of blood such as packed cells, plasma, gamma globulin, etc., are not subject to the whole blood deductible.

B. Deductible.—In each spell of illness, hospital insurance payment to any provider must be reduced by the cost of the first 3 pints of whole blood furnished to the patient. The whole blood deductible applies only to the first 3 pints of blood furnished in any spell of illness, even though more than one provider furnishes blood. The patient may be charged the **cost** of not more than the first 3 pints of whole blood furnished him during the spell of illness.

The whole blood deductible is in addition to any other applicable deductibles and coinsurance amounts for which the patient is responsible. However, the hospital or other provider cannot charge the patient for the cost of any part of the first 3 pints of blood which is replaced on a pint-for-pint basis. The deductible involves only the cost of the blood itself. The cost of **administering, storing, and processing** whole blood is not part of the whole blood deductible and is covered by the hospital insurance program whether or not the blood is replaced. If the charge to the patient for whole blood exceeds the cost of the blood furnished, the payment to the hospital is reduced by the amount of the excess charge.

In some instances, a hospital may customarily require replacement of blood in an amount greater than that furnished the patient, e.g., a patient furnished 3 pints of blood may be required to arrange for replacement of 4 pints. A patient may replace blood in accordance with the customary blood replacement policy. However, the hospital may not charge the patient who fails to comply with a request to donate blood beyond that which he was furnished and which he replaced on a pint-for-pint basis.

225. COINSURANCE

The patient is responsible for a coinsurance amount, initially \$10 (one-fourth of the inpatient hospital deductible), for each day after the 60th day and through the 90th day of inpatient hospital services furnished during a spell of illness.

Although the pre-entitlement period of hospitalization in a tuberculosis or psychiatric hospital counts in determining the 90-day limit on inpatient hospital services in the initial spell of illness (see § 217), this pre-entitlement period of hospitalization does not count in determining the 60-day period to which the coinsurance amount does not apply. This period must fall within a spell of illness, and a spell of illness

cannot begin until a month in which the individual is entitled to benefits.

Example: An individual has been an inpatient of a tuberculosis hospital for 15 consecutive days prior to July 1, 1966, the date he became entitled to hospital insurance, and he continues to be hospitalized. Although he was not entitled to benefits during the month of June, the 15 inpatient days in June count toward the 90-day limit on inpatient services for the spell of illness beginning July 1. His responsibility for the \$10 per day coinsurance begins August 30, 1966, which is the 61st day in the spell of illness begun on July 1, 1966. He would then have only 15 days remaining in that spell of illness for which payment could be made for inpatient hospital services, and to which the coinsurance amount would apply.

Outpatient Hospital Services

230. OUTPATIENT HOSPITAL SERVICES—GENERAL

Hospitals provide two distinct types of services to outpatients, namely (1) services that are diagnostic in nature, and (2) nondiagnostic services incident to physicians' professional services. The outpatient hospital diagnostic services are covered under Part A. All other hospital services provided on an outpatient basis which are incident to physicians' services rendered to outpatients are covered under Part B. The hospital is reimbursed for both types of services on a reasonable cost basis.

230.1 Distinguishing Outpatient Hospital Diagnostic Services from Nondiagnostic Outpatient Hospital Services.—A service may be regarded as "diagnostic" if it is an examination or procedure to which the patient is subjected, or which is performed on materials derived from the patient, to obtain information to aid in the assessment of a medical condition or the identification of a disease.

There will be some visits to outpatient departments which involve both diagnostic and nondiagnostic services. The attending physician will, of course, be in the best position to make the distinctions as to types of services and where he makes such designations they will be accepted. In the absence of designations by physicians as to types of services, hospitals may use the following guidelines for distinguishing the services:

a. Treat as outpatient hospital diagnostic services (covered under Part A) any identifiable services that are diagnostic in nature, and

b. Treat all other covered clinic services and emergency services (other than the emergency hospital outpatient diagnostic services) provided by the hospital on an outpatient basis as covered under Part B.

230.2 Arrangements Made By Hospital for Outpatient Diagnostic Services.—A. For outpa-

tient hospital diagnostic services furnished under such arrangements to be covered under Part A, the services must also be furnished in the hospital or in other facilities operated by or under the supervision of the hospital or its organized medical staff. Where this hospital-supervision requirement is not met by a laboratory, reimbursement for the services the hospital obtains from such laboratory will be made to the hospital under the provisions of Part B, subject to the conditions stated in C. below.

B. Types of "Arrangements".—Hospitals currently maintain a variety of relationships with independent laboratories for the purpose of supplementing their own facilities in providing diagnostic laboratory services to their patients. Such relationships vary from the laboratory operated as a separate and independent enterprise on a lease arrangement within the hospital premises (a lease arrangement does not necessarily create an independent laboratory) to situations in which diagnostic tests are performed in privately owned independent laboratories located some distance from the hospital. Some hospitals rely routinely on independent laboratories; some obtain their services only occasionally. In some cases, detailed provisions for medical staff supervision of the work performed in the laboratory are embodied in writing; in others, the details of the supervisory arrangement may be largely a matter of verbal understanding.

C. Diagnostic Services Obtained from "Independent" Laboratories.—Where a hospital obtains laboratory services for its outpatients under arrangements with an independent laboratory, reimbursement for such services will be made to the hospital on a cost basis under the provisions of Part B. Such laboratory is required to be in substantial compliance with the Conditions for Coverage of Services of Independent Laboratories in order for its services to be covered under Part B.

D. Diagnostic Services Obtained Under Arrangements with Another Hospital's Laboratory.—Diagnostic laboratory services obtained for an outpatient of a hospital under arrangements with the laboratory of another participating hospital are reimbursable to the first hospital on a cost basis under the provisions of Part B, since the services were furnished in a facility not operated by or under the supervision of the first hospital or its organized medical staff.

Outpatient Hospital Diagnostic Services Under Hospital Insurance

231. COVERED OUTPATIENT DIAGNOSTIC SERVICES

A patient having hospital insurance coverage is entitled to have payment made for outpatient hospital diagnostic services. (Outpatient diagnostic services

are on a 20-day diagnostic study basis and not related to a spell of illness.) These services include:

a. **Diagnostic tests and related services** to the extent that they would not be excluded if performed on an inpatient basis;

b. **Drugs and biologicals** necessary for diagnostic study (see § 210.3A for definition of drugs and biologicals);

c. **The services** rendered in connection with a diagnostic study **by an intern or resident-in-training** in an approved teaching program;

d. **Other services and supplies** if customarily furnished to outpatients for purposes of diagnostic studies.

The services covered under Part A would include any diagnostic laboratory services, diagnostic x-ray tests, and any other identifiable diagnostic services which the hospital may provide. Examples would include hematology, chemistry, diagnostic x-ray, diagnostic isotope studies, EKG, EEG, electromyography, pulmonary function studies, BMR, etc.

If the beneficiary has coverage only under the medical insurance plan, payment for the diagnostic services can be made under Part B. (See § 240.2 for Part B diagnostic services.)

232. OUTPATIENT STUDY PERIOD

A diagnostic study is a period of **20 consecutive days beginning** with the first day, not included in a previous diagnostic study, on which the patient is furnished outpatient hospital diagnostic services. The diagnostic services furnished during a study must be furnished by or under arrangements made by the **same hospital**. A subsequent study may not begin in or under arrangements made by the same hospital until the prior study period has been completed. However, two or more studies may be conducted concurrently in different hospitals. **The study ends** after 20 days regardless of the number of days on which diagnostic services were actually furnished. Diagnostic services which continue beyond 20 days are considered to be in a new study period and must be separately billed.

232.1 Deductible for Outpatient Hospital Diagnostic Services.—The deductible for outpatient hospital diagnostic services for each 20-day diagnostic study period is one-half the inpatient hospital deductible, initially \$20. This deductible amount counts as an incurred expense for individuals having medical insurance coverage. (See §§ 245–248 for explanation of supplementary medical insurance coverage, deductible, coinsurance, and relation to the Part A outpatient diagnostic deductible.)

232.2 Coinsurance for Outpatient Hospital Diagnostic Services.—After satisfying the deduct-

ible the patient is responsible for a coinsurance amount equal to 20 percent of the reasonable charges or customary charges, whichever is less, for the diagnostic services rendered during the diagnostic study.

Hospital Services Under Supplementary Medical Insurance

240. COVERED SERVICES

Payment may be made under the supplementary medical insurance plan for certain hospital services unless they would otherwise constitute inpatient hospital services, extended care services, or home health services. Items and services **furnished by others under arrangements** made with them by the hospital must be furnished in accordance with the requirements explained in § 207.

240.1 Services and supplies (including drugs and biologicals which cannot be self-administered) incident to physicians' services rendered to outpatients of hospitals are covered.

A. Hospital services incident to physicians' services in an outpatient department include, in general, all outpatient services provided by the hospital in clinic or emergency visits, except identifiable diagnostic services as described in § 230. This would include, for example, the services of a nurse, physical therapist, or occupational therapist assisting the physician and under his supervision.

B. Supplies incident to physicians' services are those necessary to the physicians' services in the outpatient department, e.g., surgical supplies, surgical dressings, the use of an emergency room, cast room, and operating room for minor surgery. **Drugs and biologicals** administered to outpatients must be of the type which cannot be self-administered. These are generally limited to those administered by injection, including those required on a continuing basis, such as for pernicious anemia or arthritis. However, if the injection is of the type which is commonly self-administered, such as insulin injections, the drug or biological is excluded unless it is administered to the patient in an emergency situation. (For definitions of drugs and biologicals and combination drugs see § 210.3A.)

Whole blood administered to outpatients is not subject to the whole blood deductible.

Payment may not be made for immunization, i.e., vaccination or inoculation against diseases such as smallpox, polio, diphtheria, etc. "Immunization" for this purpose, however, does not include a vaccination or inoculation related to the treatment of a particular injury or direct exposure, e.g., antirabies treatment,

tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin.

Prescription and nonprescription drugs and biologicals purchased by or dispensed to a patient are not covered.

C. Interns and Residents-in-Training. Services performed by interns and residents-in-training as part of their training program can only be reimbursed on a cost basis. Services of residents-in-training and interns which are covered under the medical insurance program include:

1. Nondiagnostic outpatient hospital therapeutic services performed by residents-in-training and interns as part of an approved or an unapproved teaching program.

2. Inpatient medical and surgical services and outpatient diagnostic medical and surgical services which are performed by residents-in-training and interns as part of a training program which is **not** an "approved program."

See § 210.5 (inpatient hospital) and § 230e. (outpatient hospital diagnostic) for description of coverage under Part A of other services which interns and residents-in-training perform.

240.2 Diagnostic x-ray, laboratory, and other diagnostic tests including materials and the services of technicians. Some examples of other diagnostic tests are basal metabolism readings, electroencephalograms, electrocardiograms, respiratory function tests, cardiac evaluations, radioactive uptake, allergy, and prothrombin time tests.

Payment may not be made under the supplementary medical insurance plan for outpatient hospital diagnostic services if such services are covered as outpatient diagnostic services under the hospital insurance plan, and the patient has Part A coverage.

Diagnostic x-ray, or anatomical, or clinical pathology services furnished by an independent laboratory are covered under medical insurance only if the laboratory is either licensed under State or applicable local law or is approved as meeting the requirements for licensing by the State or local agency responsible for licensing laboratories. Such laboratories must also meet the health and safety requirements prescribed by the Secretary of Health, Education, and Welfare. See "Conditions for Coverage of Services of Independent Laboratories."

Diagnostic laboratory services may be furnished under Part B even if not furnished in facilities operated by or under the supervision of the hospital as required for outpatient hospital diagnostic services under Part A. (See §§ 230 ff.)

240.3 X-ray, radium, and radioactive isotope therapy, including materials and services of technicians.

240.4 Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations. Surgical dressings include therapeutic and protective covering for lesions either on the skin or opening to the skin. Splints, casts, etc., include dental splints.

240.5 Rental of Durable Medical Equipment.—Durable medical equipment is equipment which can withstand repeated use. It includes such items as iron lungs, oxygen tents, hospital beds, wheelchairs, and other ambulation devices such as crutches and walkers. It must be for use in the patient's home or in a place used as his home, such as a home for the aged or a relative's home.

NOTE: The cost of repairs to durable medical equipment already owned by the patient is also covered.

240.6 Ambulance Service.—An ambulance is a specially designed or equipped automobile or other vehicle operated by trained personnel for transporting the sick or injured. It must have customary patient care equipment such as a stretcher, clean linens, first-aid supplies, oxygen equipment, etc., and it must also have adequate safety equipment required by State or local authorities. The ambulance must be operated by personnel specifically trained for ambulance service who have completed the standard and advanced Red Cross first-aid courses, or have equivalent training.

To constitute "ambulance service," transportation in such a vehicle is limited to situations where:

a. It is required by the patient's condition, **and**

b. The patient is transported to the nearest hospital with appropriate facilities or to one in the same locality, from one hospital to another, to the patient's home (or place used as his home) or to an extended care facility, or to a hospital where he had formerly been treated if that hospital is within a reasonable distance, **and**

c. Such transportation is not merely for the convenience of the patient.

240.7 Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) and replacements or repairs for such devices. The term "internal body organ" includes the lens of an eye and all or part of an ear or nose. Prostheses replacing the lens of an eye include postsurgical eyeglasses customarily used during convalescence from eye surgery, or prosthetic lenses required by the aphakic patient.

240.8 Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes supplied only on a physician's order. Back braces include, but are not limited to, special corsets, sacroiliac, sacro-

lumbar and dorsolumbar corsets, and belts. Replacements are included if required because of a change in the patient's physical condition. Repairs to and adjustment of such appliances, where necessary, are also included even when the appliance had been in use before the user enrolled in the supplementary medical insurance program.

Supplementary Medical Insurance— Deductible and Coinsurance

245. INCURRED EXPENSES

The supplementary medical insurance plan includes coverage for expenses incurred in connection with

1. Physician services.

Physician means a doctor of medicine or osteopathy (including osteopathic practitioner) legally authorized to practice by a State in which he performs the function or action. A doctor of dental surgery or dental medicine having State authorization to practice is also defined as a physician but only for surgery related to the jaw or any structure contiguous to the jaw, or the reduction of a fracture of the jaw or any facial bone. (These services must be services that could be performed by either a qualified physician or dentist; routine dental care is not included.) The services performed by physicians within these definitions are subject to any limitations imposed by the State on the scope of practice.

Regardless of the actual expenses for physician services incurred in the treatment of mental, psychoneurotic, or personality disorders of persons who are not inpatients of hospitals, the amount of such expenses that can be counted in a calendar year is limited to the lesser of \$312.50 or 62.5 percent of the actual expenses.

2. Services and supplies furnished incident to a physician's services of the kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in physicians' bills.

3. Home health services for up to 100 visits during a calendar year. (These are in addition to the 100 visits payable under hospital insurance.)

4. Outpatient diagnostic service deductibles imposed under the hospital insurance plan for diagnostic studies during the calendar year. (See § 248 for further explanation of the outpatient hospital diagnostic deductible as an incurred expense under supplementary medical insurance.)

5. Other medical and health services.

246. DEDUCTIBLE

In each calendar year a deductible of \$50 must be satisfied before payment can be made under the sup-

plementary medical insurance plan. However, expenses incurred in the last 3 months of the previous year **which were applied toward the medical insurance deductible for that year**, may also be applied against the deductible for the current year. Except to the extent that the prior year's expenses are counted, the deductible is satisfied by the initial medical insurance expenses incurred in the current year. Even though an individual is not eligible for the entire calendar year, i.e., his medical insurance coverage begins after the first month of the year, he is still subject to the full \$50 deductible.

247. COINSURANCE

After the deductible has been satisfied providers will be paid 80 percent of the reasonable costs, and physicians and other suppliers 80 percent of the reasonable charges, incurred during the balance of the calendar year. The patient is responsible for a coinsurance amount equal to 20 percent of the reasonable charges for the items and services furnished.

248. OUTPATIENT HOSPITAL DIAGNOSTIC DEDUCTIBLE AS AN INCURRED EXPENSE UNDER THE SUPPLEMENTARY MEDICAL INSURANCE PLAN

The amount of any outpatient hospital diagnostic services deductible(s) incurred by an individual during the calendar year under hospital insurance, is included as an incurred expense under supplementary medical insurance. It may be used to help satisfy the medical insurance deductible, and it is reimbursable under medical insurance if that deductible has been satisfied.

The outpatient diagnostic deductible is the only exception to the rule that payment for services may not be made under medical insurance if the patient was entitled (except for the deductibles and coinsurance) to have payment made for those services under hospital insurance.

A hospital need not charge the full amount of the Part A outpatient hospital diagnostic deductible if the patient has already satisfied the \$50 Part B deductible. The hospital's record may indicate that the Part B deductible is met, or the patient may have a utilization notice (see § 304) which shows this. The hospital would charge the patient only 20 percent of his total bill for the study, and any other outpatient services furnished. The outpatient diagnostic deductible will be considered a medical insurance item and the hospital will be reimbursed for 80 percent of it under Part B. If the hospital collects the full amount of the outpatient diagnostic deduct-

ible from the patient because it is not aware that the Part B deductible has been met, the intermediary will reimburse the patient for 80 percent of the Part A deductible amount he paid. (See § 420 for billing information.)

Hospital-Based Physicians

255. HOSPITAL-BASED PHYSICIANS' SERVICES

The medical insurance program covers physicians' services (except services of interns or residents-in-training under an approved teaching program) rendered to individual beneficiaries in or out of the hospital. The charges of hospital-based physicians (e.g., those on salary) including radiologists, anesthesiologists, pathologists, physiatrists, and others for services directed to the medical care of the individual patient must be specially billed either by the physician or by the hospital on his behalf. However billed, reimbursement is made on a reasonable charge basis by the supplementary medical insurance (Part B) intermediary. Thus the **charges** for physicians' services rendered individual beneficiaries are allocated to the medical insurance program and distinguished from the **cost** of hospital services payable under either the hospital or medical insurance plan. (See § 430 for billing by hospital for these services.)

Hospital-based physicians often perform services other than those clearly directed to the medical care of individual patients. These may involve teaching and administrative services, and services that benefit the hospital's patients as a group. Such physician services, not directly related to an individual patient, if compensated, must be considered in computing reimbursable hospital costs and, as such, will be reflected in amounts payable to the hospital for services rendered program beneficiaries. (Detailed information on cost computation is contained in reimbursement principles. These principles also cover the option available in billing for the services of pathologists and radiologists.)

General Exclusions From Coverage

260. GENERAL EXCLUSIONS

No payment may be made under *either* the hospital insurance plan or the supplementary medical insurance plan for:

260.1 Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

260.2 Items and Services for Which There Is No Legal Obligation To Pay.—This exclusion does not apply if the patient has a legal obligation to pay, or

some other person or organization has a legal obligation to pay for or provide the items or services. Thus, for example, the exclusion does not apply to care provided or paid for by a prepayment plan.

Free services are excluded from coverage, e.g., free chest x-rays provided by health organizations. In applying this exclusion the determining factor is that there is no legal obligation to pay for the items or services, and not merely the fact that the patient is not charged because of other considerations. This exclusion, therefore, does not prohibit program payment for services rendered to members of religious orders who are not charged because of a vow of poverty or to indigents who are not charged because of their inability to pay.

Covered services furnished to residents of a **home for the aged** are not excluded where payment is sought from the resident for maintenance and health services to the extent of his ability to pay. This would be the case, for example, where at the time of admission the resident assigns to the home any assets or income he may have. However, where all services are furnished by the home on a purely charitable basis (i.e., no payment is accepted from residents regardless of their ability to pay), payment could not be made under the health insurance program for items and services furnished by the home. In this situation, however, payment could be made for services furnished by a source independent of the home if that source customarily charges for such services. Thus, payment could be made for services furnished by an independent hospital to which a resident of the home is sent.

Certain union homes accept no payment from residents regardless of their ability to pay. Payment may, nevertheless, be made for services provided by such homes where admission to the home and access to the services is a matter of right for union members who meet the necessary qualifications.

Payment may also be made for services to a patient whose need for services resulted from the act or negligence of another who is or may be legally liable for the patient's medical expenses. The existence of a third person's liability does not affect the patient's obligation to pay for the services he receives.

260.3 Items and services which are paid for by a governmental entity other than under the Social Security Act or under a health benefits or insurance plan for employees of the governmental entity. The Secretary of Health, Education, and Welfare may specify other exceptions to this exclusion. The Secretary has approved payment for services, which are otherwise covered, if they are furnished in qualified State or local government-operated hospitals serving the general community, including psychiatric and tuberculosis hospitals even though the services are provided free.

260.4 Items and services which are not provided within the United States (except for emergency inpatient hospital services furnished outside the United States under the conditions described in § 202 and payment on behalf of railroad beneficiaries for covered hospital insurance services furnished in Canadian hospitals). The United States includes the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

260.5 Items and services which are required as a result of war, or of an act of war, occurring after the effective date of the patient's current coverage.

260.6 Personal Comfort Items.—These are items which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member. Charges for special items requested by the patient such as radio, television, telephone, and air conditioner, and beauty and barber services are excluded from coverage. Items such as heat lamp treatments and massages are covered only when ordered by a physician.

260.7 Routine Physical Checkups, eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, **hearing aids or related examinations**, or **immunizations**. Routine physical checkups include (a) examination performed without relationship to treatment or diagnosis of a specific illness, symptom, complaint, or injury, and (b) examinations required by third parties such as insurance companies, business establishments, or Government agencies.

The exclusions apply to eyeglasses or contact lenses, and eye examinations solely for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors. The exclusions do not apply to examinations performed in conjunction with an eye disease such as glaucoma or cataracts, or to postsurgical eyeglasses which are customarily used during convalescence from eye surgery, or to prosthetic lenses required by the aphakic patient. In the last situation, the prosthetic lens is a replacement for an internal body organ—the lens of the eye.

Vaccinations or inoculations are excluded as “immunizations” unless they are directly related to the treatment of an injury or direct exposure such as anti-rabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin.

260.8 Orthopedic Shoes or Other Supportive Devices for the Feet.—The exclusion of orthopedic shoes does not apply to such a shoe if it is an integral part of a leg brace.

260.9 Custodial Care.—The custodial care exclusion precludes payment for patient care which primarily requires protective services rather than definitive medical and skilled nursing care.

260.10 Cosmetic Surgery or Expenses Incurred in Connection With Such Surgery.—Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident or surgery for therapeutic purposes, which coincidentally also serves some cosmetic purpose.

260.11 Charges Imposed by Immediate Relatives of the Patient or Members of His Household.

260.12 Items and services in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth. Payment may be made, however, for (a) surgery related to the jaw or any structure contiguous to the jaw, or (b) the reduction of any fracture of the jaw or any facial bone, including dental splints or other appliances used for this purpose.

260.13 Items and services to the extent that payment has been made, or can reasonably be expected to be made **under a workmen's compensation law** or plan of the United States or a State. Payments made for items and services under the health insurance program are subject to repayment to the appropriate trust fund if notice or information is received that payment has been made for the items and services under a workmen's compensation plan. (See §§ 289 ff.)

260.14 Items and services which the provider is obligated by a law of or because of a contract with the Federal Government to render at public expense.

260.15 Items and services furnished by a Federal provider of services or other Federal agency except (a) for emergency inpatient hospital services and emergency outpatient hospital diagnostic services furnished by a Federal hospital meeting the requirements of § 202, or (b) when the Federal provider of services has been determined by the Secretary of Health, Education, and Welfare to be providing services to the public generally as a community institution or agency.

Requirements For Payment

270. REQUEST FOR PAYMENT

Before payment can be made for an inpatient hospital stay, outpatient hospital diagnostic study, or hospital

services under medical insurance, a written request for payment signed by the patient, or by another person qualified to do so on his behalf must be filed. For convenience, the request for payment has been made a part of the respective billing forms.

271. EXECUTION OF THE REQUEST FOR PAYMENT

If at all practicable, the request should be signed by the patient at the time of admission. (See Admission Procedures, §§ 300 ff.)

In certain circumstances, it would be impracticable for an individual to sign the request for payment himself because when he is admitted to the hospital, or begins outpatient hospital diagnostic or other hospital services, he is unconscious, incompetent, in great pain, or otherwise in such a condition that he should not be asked to transact any business. In this situation, his representative payee (i.e., a person designated by the Social Security Administration to receive monthly benefits on the patient's behalf), a relative, legal guardian, or a representative of an institution (other than the hospital) usually responsible for his care, or a representative of a governmental entity providing welfare assistance should, if present at time of admission, be asked and permitted to sign on his behalf.

When no request for payment is obtained at the time of admission, the hospital should attempt to obtain such a request later from the patient or other person described above. If the request cannot be so obtained by the time the hospital would ordinarily submit its bill to the intermediary, an authorized official of the hospital may sign the request.

When someone other than the patient signs the request for payment, the signer will submit a brief statement explaining his relationship to the patient and the circumstances which made it impracticable for the patient to sign, and the hospital will forward this statement with its billing. The intermediary will generally accept such a statement as representing the true facts of the case in the absence of evidence to the contrary.

The hospital should not **routinely** sign the request on behalf of any patient. If experience reveals an unusual frequency of such hospital-signed requests from a particular hospital, the matter will be subject to review by the intermediary.

If a fully competent and capable patient **refuses** to sign the request for payment necessary for the hospital to obtain reimbursement for the services it furnished, the hospital may charge the patient or other person for covered services.

272. FILING OF THE REQUEST FOR PAYMENT

The request for payment must be filed with the intermediary, or with the Social Security Administration where the hospital deals directly with the Government.

It is desirable to have the request signed at the time of admission; the request must be filed prior to or in connection with the first billing for services.

A. A request for payment must be filed in connection with **each inpatient hospital admission**, even though multiple admissions may occur during the same spell of illness. Only one request for payment has to be filed, however, in connection with each inpatient admission, even though an extended hospital stay occasions multiple billings.

B. For **diagnostic studies and other outpatient hospital services** a signed request for payment is required with each billing by the hospital.

Certification and Recertification By Physicians

275. CERTIFICATION AND RECERTIFICATION BY PHYSICIANS—GENERAL

Payment may be made for covered hospital services only if a physician certifies to the medical necessity for the services. For services continued over a period of time, a physician must recertify the continued need for the services at specified intervals. Appropriate supporting material may be required. Failure to obtain the required certification and recertification statements in an individual case will result in the hospital not being eligible to receive payment in that case.

Hospitals will not transmit physician certification and recertification statements to the intermediary, or to the Social Security Administration if the hospital deals directly. The hospital must itself certify, on the appropriate billing form, that the required physician certification and recertification statements have been obtained and are on file. The physician certification and recertification statements will be retained in the hospital's files, where they will be available for verification, if needed.

A hospital must also have available in its files a description of the procedure it adopts on the timing of recertifications—that is, the intervals at which recertifications will be required and whether review of long-stay cases by the utilization review committee will serve as an alternative to recertification by a physician in the case of the third or subsequent recertifications.

276. INPATIENT HOSPITAL SERVICES CERTIFICATION

The inpatient hospital services certification should state the medical necessity for inpatient hospital admission. It will not be necessary to state the reason(s) why hospital admission is necessary.

The certification of the medical necessity for inpatient hospital services must be signed by the admitting physician or a medical staff member with knowledge of the case. The routine admission procedure followed by a

physician would not ordinarily of itself be sufficient certification of the medical necessity for hospitalization for purposes of the program.

Certifications must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable. However, the individual hospital determines the method by which certifications are to be obtained and the format of the certification statement. Thus, the medical and administrative staffs of each hospital may adopt the procedure they find most convenient and appropriate.

There is no requirement that the certification be entered on any specific form or handled in any specific way, as long as the approach adopted by the hospital permits the intermediary (or the Social Security Administration where the hospital deals directly with the Government) to determine that the certification requirement is in fact met. The certification could, therefore, be entered or preprinted on a form the physician already has to sign; or a separate certification form could be used.

277. RECERTIFICATION FOR INPATIENT HOSPITAL SERVICES

The recertification statement must meet the following standards: it must contain an adequate written record of the reasons for continued hospitalization, the estimated period of time the patient will need to remain in the hospital, and plans for posthospital care. The recertification statement made by the physician has to meet the content standards unless, for example, all of the required information is included in progress notes, in which case the physician's statement could indicate that the individual's medical record contains the information required by the standards and that continued hospitalization is medically necessary.

Recertifications are to be signed by the attending physician or a medical staff member with knowledge of the case. The hospital determines the form of the written record and the manner of obtaining timely recertifications. Thus, the hospital is able to adopt a procedure for obtaining timely recertifications that suits it best.

Where the requirements for the third or a subsequent recertification are satisfied by review of a stay of extended duration, pursuant to the hospital's utilization review plan, a separate recertification statement is not required. However, it is necessary to satisfy the recertification content standards. It would be sufficient if records of the utilization review committee show that consideration was given to the three items mentioned above—the reasons for continued hospitalization, estimated time the patient will need to remain in the hospital, and plans for posthospital care.

278. TIMING OF RECERTIFICATIONS

The first recertification is required no later than as of the 14th day of hospitalization. A hospital may, at its option, provide for the first recertification to be made earlier, or it may vary the timing of the first recertification within the 14-day period by diagnostic or clinical categories.

A second recertification is required no later than as of the 21st day of hospitalization. Thereafter, **subsequent recertifications** must be made at intervals established by the utilization review committee (on a case-by-case basis if it so chooses), but in no event may the prescribed interval between recertifications exceed 30 days. The utilization review committee will be reviewing long-stay cases and may be in the best position to decide when subsequent recertifications are needed.

A hospital can, if it wishes, coordinate its physician certifications with the process of review by the utilization review committee of long-stay cases. At the option of a hospital, review of a stay of extended duration under the hospital's utilization review plan may take the place of the third and any subsequent physician recertifications. (Such review may be the initial review, or a second or subsequent review of an extended-stay case by the utilization review committee.)

Where review of an extended-stay case by the utilization review committee is deemed to take the place of a physician recertification, it would be possible for the recertification to be made later than the specified day, because the review of an extended duration case may be made at any time within the 7-day period following the last day of the period of extended duration defined in the utilization review plan. Such a recertification will be treated as a delayed recertification; however, no explanation for the normal delay is required.

279. INPATIENT PSYCHIATRIC HOSPITAL SERVICES CERTIFICATION AND RECERTIFICATION

The requirements for physician certification and recertification for inpatient psychiatric hospital services are generally the same as for inpatient hospital services. However, the required content of the certification and recertification statements differs from the content of the statements required for inpatient hospital services.

The certification should state that the inpatient psychiatric hospital admission was medically necessary, for either (1) treatment which could reasonably be expected to improve the patient's condition, or (2) diagnostic study.

The recertification should state (1) that inpatient psychiatric hospital services furnished since the previous certification or recertification were, and continue to be, medically necessary for either (a) treatment which could reasonably be expected to improve the patient's condition, or (b) diagnostic study; and (2) that the

hospital records indicate that the services furnished were either intensive treatment services, admission and related services necessary for diagnostic study, or equivalent services.

For convenience, the period covered by the physician's certification and recertification is referred to as a period during which the patient was receiving **active treatment**. If the patient remains in the hospital but the period of "active treatment" ends (e.g., because the treatment cannot reasonably be expected to improve the patient's condition, or because intensive treatment services are not being furnished), program payment can no longer be made even though the patient has not yet exhausted his benefits. Where the period of "active treatment" ends, the physician is to indicate the ending date in making his recertification. If "active treatment" thereafter resumes, the physician should indicate, in making his recertification, the date on which it resumed.

280. INPATIENT TUBERCULOSIS HOSPITAL SERVICES CERTIFICATION AND RECERTIFICATION

The requirements for physician certification and recertification for inpatient tuberculosis hospital services are generally the same as for inpatient hospital services. However, the required content of the certification and recertification statements differ from the content of the statements required for inpatient hospital services.

The **certification** should state that the inpatient tuberculosis hospital admission was medically necessary for treatment which could reasonably be expected either to (1) improve the patient's condition, or (2) render the condition noncommunicable.

The **recertification** should state (1) that the inpatient tuberculosis hospital services furnished since the previous certification or recertification were, and continue to be, medically necessary for treatment which could reasonably be expected either to (a) improve the patient's condition, or (b) render the condition noncommunicable; and (2) that the hospital records indicate such medical necessity.

For convenience, the period covered by the physician's certification and recertification is referred to as a period during which the patient was receiving **active treatment**. If the patient remains in the hospital but the period of "active treatment" ends (e.g., because the treatment cannot reasonably be expected to improve the patient's condition), program payment can no longer be made even though the patient has not yet exhausted his benefits. Where the period of "active treatment" ends, the physician is to indicate the ending date in making his recertification. If "active treatment" thereafter resumes, the physician should indicate, in making his recertification, the date on which it resumed.

281. OUTPATIENT HOSPITAL DIAGNOSTIC SERVICES CERTIFICATION

A physician should state that outpatient hospital diagnostic services are required for a diagnostic study.

Certification as to outpatient diagnostic services may be made on the physician's orders, on the copy of the summary prepared at the conclusion of the study that is retained by the hospital, or a special form may be used.

Recertification is not required for outpatient hospital diagnostic services. However, if the diagnostic service extends beyond 20 days, a new certification is required for each study period.

282. CERTIFICATION FOR HOSPITAL SERVICES COVERED BY THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

A physician must certify that the medical and other health services covered by medical insurance which were provided by (or under arrangements made by) the hospital were medically required.

In cases in which the hospital provides ambulance service to transport the patient from the scene of an accident and no physician is involved until the patient reaches the hospital, any physician in the hospital who examines the patient or has knowledge of the case may certify to the medical need for the ambulance service.

This certification requires a brief description of the services and the signature of the physician. It need be made only once for a course of treatment. Where services are provided on a continuing basis, such as a course of radium treatments, the physician's certification may be made at the beginning or end of the course of treatment, or at any other time during the period of treatment.

There is no requirement that the certification be entered on any specific form or handled in any specific way, as long as the approach adopted by the hospital permits the intermediary (or the Social Security Administration where the hospital deals directly with the Government) to determine that the certification requirement is in fact met. The certification could, therefore, be entered or preprinted on a form the physician already has to sign; or a separate certification form could be used.

283. DELAYED CERTIFICATIONS AND RECERTIFICATIONS

Hospitals are expected to obtain timely certification and recertification statements. However, delayed certifications and recertifications will be honored where, for example, there has been an oversight or lapse.

In addition to complying with the appropriate content requirements, delayed certifications and recertifications must include an explanation for the delay and any medical or other evidence which the hospital considers relevant for purposes of explaining the delay. The

hospital will determine the format of delay certification and recertification statements, and the method by which they are obtained. A delay certification and recertification may appear in one statement; separate signed statements for each certification and recertification would not be required as they would if timely certification and recertification had been made.

284. TIMING OF CERTIFICATION AND RE-CERTIFICATION FOR BENEFICIARY ADMITTED BEFORE ENTITLEMENT

If an individual is admitted to a hospital (including a psychiatric or tuberculosis hospital) before he is entitled to hospital insurance benefits (for example, before July 1, 1966, or before he reaches age 65), the following rules are applicable when he does become entitled.

No certification as to the medical necessity for inpatient admission is required. Recertifications are required as of the time they would be required if the patient had been admitted to the hospital on the day he became entitled. For example, if a patient becomes entitled to Part A benefits on July 1, 1966, but was admitted prior to that date, the first recertification is required no later than July 14; the second recertification is required no later than July 21; subsequent recertifications are required at intervals not to exceed 30 days. Similarly, if a patient becomes entitled on September 1, but was admitted prior to that date, the first recertification is required no later than September 14; the second, no later than September 21, and so forth.

Special Provisions Related to Payment

285. REFUNDS

In its participation agreement the hospital agrees not to charge for items or services for which an individual is entitled to have payment made on his behalf. Thus, when the patient's eligibility is verified, in order to have payment made under health insurance, the hospital is obliged to refund to the proper party any payments previously collected from beneficiaries, other insurance carriers, welfare, or others for covered services, except for deductibles, coinsurance amounts, and noncovered charges.

286. GUARANTEE OF PAYMENT PROVISIONS

A hospital may be paid, under certain conditions, for inpatient hospital services furnished to a beneficiary whose eligibility for inpatient hospital benefit days in a spell of illness has been exhausted. The guarantee also extends to inpatient psychiatric hospital services furnished to an individual who has used up his 190-day lifetime limitation on such services. The provision assures at the time of admission that payment will be made to a hospital for its services during the time it takes to notify the hospital of the patient's utilization

record. The guarantee includes not only cases in which it turns out that benefits were already exhausted prior to admission, but cases where a beneficiary had some inpatient hospital benefits remaining at the time of his admittance to a hospital; e.g., 2 or 3 days of remaining eligibility, but these benefits are exhausted before the intermediary's reply to the notice of admission reaches the hospital. The guarantee applies only to inpatient hospital services and not to other benefits provided under the hospital or medical insurance programs. A hospital is not required to claim payments under this provision; it may look to the patient for payment.

286.1 Requirements for Payment Under the Guarantee.—The following conditions must exist for a hospital to receive payments under this provision:

a. The services provided by the hospital must be covered for inpatient hospital purposes.

b. The hospital must have acted in good faith in assuming that the individual was entitled to inpatient hospital benefits. There would be an absence of good faith if the hospital had, or should have had, a substantial doubt that coverage existed.

c. There must have been reasonable grounds for the hospital's assumption that entitlement to benefits existed.

d. The hospital must agree to refund any payment received from the patient, or on his behalf, for the covered services furnished.

With its bill, the hospital will submit an explanatory statement describing the circumstances which led it to believe that the patient had remaining days of eligibility. If the information is not furnished with the bill, the intermediary will request it.

286.2 Maximum Number of Days Under Guarantee.—The intermediary (or the Social Security Administration) may pay the hospital for inpatient hospital services furnished for up to 6 days after the day of admission. Saturdays, Sundays, legal Federal holidays, and the first calendar day of admittance to the hospital will be omitted in computing the 6 elapsed days. However, no payment is made for any day after the day the hospital receives a notice of lack of entitlement. The notice may be furnished by mail, messenger, wire, or telephone. If notice is given by telephone, a confirmation in writing will be furnished to the hospital; the date of the telephone message will be considered the date of notification.

In determining the days covered by the guarantee, legal Federal holidays are:

New Year's Day
Washington's Birthday
Memorial (Decoration) Day
Independence Day
Labor Day

Veterans Day
Thanksgiving Day
Christmas Day

Exclusion of Federal nonworking days prolongs the period covered by the guarantee. When a Federal holiday occurs on a Sunday, the day following is observed as a Federal nonworkday and, therefore, would not be counted as an elapsed day. When the holiday falls on Saturday, the prior Friday would not be counted as an elapsed day. The hospital will be paid on behalf of the beneficiary for all the days of inpatient services within the guarantee period; i.e., weekends, holidays, and the day of admittance will be included in computing the benefit amount due the hospital.

286.3 Recovery of Funds Advanced Under Guarantee Provision.—Benefits paid to hospitals under the guarantee provisions are subject to recovery from the cash benefits to which a beneficiary is entitled under the Social Security or Railroad Retirement Act. Such benefits may be suspended or reduced until the amount advanced to the hospital has been repaid, unless recovery is waived.

289. WORKMEN'S COMPENSATION

Payment is excluded for any items or services to the extent that payment has been made, or can reasonably be expected to be made, under a workmen's compensation law or plan of the United States or a State. Health insurance payment for items or services is conditioned on reimbursement to the hospital or supplementary medical insurance trust fund when notice or information is received that payment for them has been made under workmen's compensation.

289.1 Effect of Workmen's Compensation Payments on Eligibility and Spell of Illness.—An individual's spell of illness will begin with the first day he receives inpatient services from a qualified hospital or extended care facility even though workmen's compensation coverage, rather than the health insurance program, pays for those services, if he is entitled to hospital insurance benefits in that month. However, inpatient hospital service days will not be charged against the patient's 90 days of eligibility until the first day for which payment may be made under the hospital insurance program. Charging of days will generally begin when the workmen's compensation coverage expires, since payment can then be made under hospital insurance if the stay continues or there is a subsequent stay not covered by workmen's compensation.

289.2 General Procedures in Workmen's Compensation Cases.—When the hospital is told that the patient's illness or injury is employment related, this will be indicated on the billing form, and the employer's name and address given.

If the patient has already received a workmen's compensation payment for the current illness or injury (e.g.,

he was hospitalized before the current admission) the hospital should furnish the intermediary any information available with the admission notice, since it is possible that subsequent hospitalization for the same condition may also be compensable under workmen's compensation. If there is a possibility of workmen's compensation coverage, the hospital should file a claim with the workmen's compensation carrier.

Even though workmen's compensation payment has been or probably will be made, the hospital should submit a bill for covered health insurance services in the usual manner to the intermediary, or to the Social Security Administration if the hospital deals directly with the Government.

a. If the hospital has received a workmen's compensation payment, the intermediary will deduct the amount of that payment which was for covered health insurance services from the hospital's bill. The hospital will be notified by the intermediary of the extent to which its bill was covered by workmen's compensation. The patient will also be notified of this action.

b. If there is a reasonable likelihood that the hospital will be paid by workmen's compensation for the patient's care, the intermediary will notify the hospital that health insurance payments are precluded because of the expected workmen's compensation payment. The patient is also notified of this decision.

If workmen's compensation does not pay or pays only in part for covered services, the hospital may reopen the question of its bill with the intermediary.

c. If the intermediary determines that workmen's compensation payments cannot reasonably be expected, it will pay the hospital for covered health insurance services on condition that the payment will be refunded if workmen's compensation later pays for the services. No conditional payment will be made unless workmen's compensation payment is doubtful (e.g., where the employer is contesting his liability under the workmen's compensation or his liability for the expenses in question).

290. UTILIZATION REVIEW PLAN

A qualified hospital is required to have in effect a plan for utilization review which applies to the inpatient services the hospital furnishes to patients entitled to benefits under the health insurance program. The plan must provide for review, on a sample basis, of admissions, duration of stays, and professional services furnished; and review of each case of continuous extended duration while the patient is in the hospital. The detailed requirements for an acceptable utilization review plan are set out in § XVI of the "Conditions of Participation for Hospitals."

The law requires that effective utilization review be maintained on a continuing basis to assure the medical

necessity of the services for which the program pays and promote the most efficient use of available health facilities and services.

290.1 Definition of Extended Stay—Beneficiary Admitted Before Entitlement.—The general rule for the review of extended-stay cases is explained in § XVI of the “Conditions of Participation for Hospitals.” If an individual is admitted to a hospital before he is entitled to hospital insurance benefits (for example, before July 1, 1966, or before he reaches age 65), the following rules are applicable when he does become entitled.

In identifying cases of extended duration for review by the utilization review committee in those hospitals which provide for the review of beneficiary cases only, the patient will be considered to have been admitted to the hospital on the day he became entitled to hospital insurance benefits. For example, if a hospital has defined extended stay as being 20 days of hospitalization, a patient who becomes entitled to Part A benefits on July 1, 1966, but who was admitted prior to that date, would be considered as an extended-stay case for utilization review purposes on July 21, 1966. Similarly, if a patient becomes entitled on September 1, but was admitted prior to that date, the patient will be considered as an extended-stay case for utilization review purposes on September 21.

290.2 Further Inpatient Stay Not Medically Necessary.—If in the review of an extended-stay case the physician members of the utilization review committee decide, after opportunity for consultation is given the attending physician, that further inpatient stay is not medically necessary, notification in writing is given within 48 hours to the institution, the attending physician, and the patient. Payment cannot be made for more than 3 days of inpatient hospital services after the date the notice is received by the hospital.

290.3 Failure To Make Timely Review Of Cases.—If the Social Security Administration determines, on the basis of information obtained by an intermediary during the course of its ongoing review of utilization practices, that a hospital has substantially failed to make timely review of long-stay cases, it may, in lieu of terminating its agreement with the hospital, decide that no payment may be made on behalf of patients for more than 20 consecutive days of inpatient hospital services. The Administration will determine the effective date of this limitation. It would be applicable to services provided to individuals admitted to the hospital after that date. Notice of the decision must be given to the hospital and to the public.

The limitation will be removed when it is determined that timely review of long-stay cases has been restored

and there is reasonable assurance that the deficiency will not recur.

Appeals of Payment Determinations

295. HOSPITAL PROTEST OF PAYMENT DETERMINATION

The hospital and its intermediary should attempt to resolve mutually any differences involving payment for services that arise from the application of the cost formula or the amount payable in a specific case. While no appeal is available for hospitals or other providers from intermediary determinations involving payments, provider complaints and protests will be considered in Social Security Administration review of the intermediary's application of the cost formula or its compliance with the other terms of its agreement with the Government.

296. BENEFICIARY PROTESTS AND APPEALS OF PAYMENT DETERMINATIONS

A. Hospital Insurance Program.—An individual dissatisfied with any determination of the amount of benefits payable on his behalf under hospital insurance may have his claim reconsidered by the Social Security Administration. If he is not satisfied with the reconsideration determination and the amount in controversy is \$100 or more, he may request a hearing by the Social Security Administration. If the amount in controversy is \$1,000 or more and he is dissatisfied with the hearing decision, the individual may initiate action for Federal court review of the claim.

B. Medical Insurance Program.—An individual dissatisfied with denial of a request for payment of medical insurance benefits, or with the amount of medical insurance benefits paid, or with the promptness with which his request for payment is acted upon is entitled to an opportunity for a review by, and if still dissatisfied, to a fair hearing by the medical insurance intermediary. Since the hospital is paid for the medical insurance services it furnishes by the same intermediary that makes hospital insurance payments to the hospital, this intermediary is responsible for the review and hearing under medical insurance.

A patient dissatisfied with a payment for the services of a hospital-based physician is entitled to a review by and, if still dissatisfied, to a fair hearing by the medical insurance intermediary to whom the bill for the physician's services was submitted for payment.

C. Patient protests concerning entitlement to health insurance benefits, or the denial, amount, or promptness of payment for items or services furnished

by the hospital under hospital or medical insurance should be handled, if simply amenable to explanation or correction, by the hospital. If he is still dissatisfied, the patient should be referred to his social security district office. The district office can offer assistance to the

beneficiary in determining his appeal rights and can answer specific questions about the appeal procedures. The district office can also assist the individual in completing the necessary forms for requesting reconsideration or hearing.

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ADMISSION PROCEDURES

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Chapter III

ADMISSION PROCEDURES

300. SUMMARY OF ADMISSION PROCEDURES

The purpose of this section is to give a brief outline of routine handling of admissions. Detailed instructions on procedures as well as descriptions of special situations are given in subsequent sections.

The first step in preparing the Notice of Admission in inpatient cases is to ask the patient for his health insurance card. **It is very important that the claim number on this card be accurately recorded on the admission notice since the case cannot be processed if the number is missing or incorrect.**

If you cannot obtain the health insurance claim number from the patient, you should get in touch with the Social Security Administration district office for help.

The second step is to ask the patient if he has been an inpatient in any hospital or extended care facility during the prior 60 days. If he has, he may have less than the full 90 days of inpatient eligibility remaining in the current spell of illness. Your intermediary (or the Social Security Administration if you are dealing directly with the Government) will make any necessary verification of these prior stays.

The third step is to fill in the other items on the admission form, have the patient sign the form (see §§ 270 ff), and send the information to your intermediary or the social security district office if you deal directly.

Your intermediary will check the Social Security Administration central record, then send you a reply giving the patient's remaining days of eligibility and deductible status so that you can prepare the billing form.

In outpatient cases you will go through the same steps of asking for the health insurance card to establish whether the patient is entitled under Part A and Part B, and to obtain the correct health insurance claim number. However, the admission information will be sent to your intermediary at the same time you forward your billing. (See § 420.1 for completing admission items for outpatient hospital services.)

302. HEALTH INSURANCE CARD

The Social Security Administration maintains in Baltimore, Maryland, the records of all persons entitled to health insurance. After entitlement is established each beneficiary is issued a health insurance card by the central office of the Social Security Administration (or in some cases by the Railroad Retirement Board) for use in obtaining hospital insurance benefits, medical insurance benefits, or both. The health insurance claim number on the card is essential in locating the patient's record when a claim for benefit payment is made. **No admission notice or billing form should be forwarded without the correct claim number.** Exhibit 1 of this chapter shows the health insurance cards and briefly explains the numbering system as an aid in recognizing valid numbers.

The hospital should ask each patient who gives his age as 65 or more for his health insurance card to determine his health insurance entitlement status and obtain the correct health insurance claim number. When the hospital knows in advance of an impending stay by a 65 year-old patient, it should advise the prospective patient that he is to furnish his health insurance card when admitted, or suggest that he get in touch with the SSA district office if he does not have one. If a patient already in the hospital is within 3 months of age 65 and has not applied for hospital insurance entitlement, it will be helpful if he, or someone on his behalf, is advised to contact the district office. The hospital may wish to arrange with the district office to bring such cases routinely to the attention of the district office.

A health insurance card is acceptable without a signature. However, the patient should be asked to sign the card if he has not already done so.

304. NOTICE OF HOSPITAL (OR MEDICAL) INSURANCE UTILIZATION OR EXPLANATION OF BENEFITS

If the patient cannot furnish his health insurance card when admitted, he may have a health insurance utilization form which shows his claim number. Form SSA-1533, Notice of Hospital Insurance Utilization (see Exhibit 2) is mailed to a beneficiary from the Social Security Administration in Baltimore shortly after Part A inpatient hospital, extended care, or home

health benefits have been paid on his behalf. Form SSA-1533a, Notice of Medical Insurance Utilization (see Exhibit 3) is mailed to a beneficiary by SSA after payment of Part B home health benefits. An Explanation of Benefits is sent to a beneficiary by the Part B intermediary after payment of a supplementary medical insurance claim. The Part A intermediary sends the beneficiary a utilization notice after payment on his behalf for Part A or Part B outpatient hospital services. These forms, if current, may also indicate to the hospital the patient's remaining eligibility under hospital insurance, or deductible status under supplementary medical insurance. **However, an admission notice must always be sent in inpatient cases regardless of the currency of any of these forms.**

306. CONTACTS WITH THE SSA DISTRICT OFFICE TO OBTAIN HEALTH INSURANCE CLAIM NUMBERS

When a patient cannot furnish the health insurance claim number, it will be requested from the SSA district office. Ordinarily, the social security district office will have arranged with the hospital for handling these requests. If it has not, the hospital should get in touch with the nearest district office to make such arrangements. Apart from assisting in determining correct claim numbers, the district office can help a beneficiary to replace a lost health insurance card.

306.1 Information Required by SSA District Office.—If the patient's social security account number is available, the district office will usually require no additional information to locate the claim number or determine that the patient has not established health insurance entitlement.

If the patient has ever been employed or self-employed, or sought employment, or filed Federal Income Tax Returns, he should have a social security card. This card contains his social security account number which consists of 9 digits, 000-00-0000, but does not have the letter prefix or suffix which distinguishes the health insurance claim number. (See Exhibit 1.)

A social security account number is *not* sufficient for processing a claim.

If the account number is not available, the following information should be furnished.

a. The patient's name and statement as to whether or not he ever applied for social security monthly benefits, railroad retirement benefits, or for hospital insurance benefits;

b. If the patient says he applied, the name of the person on whose social security account the application was based, e.g., his own account or the account of a husband or a wife;

c. The patient's father's full name, mother's maiden name, and the patient's date and place of birth;

d. Patient's address.

If the hospital cannot give all the identifying information required from the beneficiary, it should furnish as much as it has to the SSA district office.

306.2 The SSA District Office Reply.—The SSA district office will furnish the health insurance claim number as soon as possible. If the claim number is not available, it will inform the hospital of the action it is taking.

If an application for hospital insurance benefits is taken as a result of the request to the district office for a claim number or is pending when the hospital requests a claim number, the district office will inform the hospital when processing is completed. It will give the hospital the claim number if the patient is entitled to hospital insurance benefits. The hospital may then send the notice of admission information to the intermediary (or to the district office if the hospital deals directly with SSA).

308. HOSPITAL ADMISSIONS WHERE A HEALTH INSURANCE CLAIM NUMBER IS NOT AVAILABLE AND PATIENT'S CONDITION IS CRITICAL

Occasionally a patient age 65 or older is admitted to a hospital in a critical condition, a health insurance claim number is not available, and there is some question whether he has established health insurance entitlement. If the patient's condition is critical, the normal procedures of contacting the district office may not afford sufficient protection of the individual's benefit rights. In such cases, the hospital should have a Form SSA-18, Application For Hospital Insurance (or a comparable protective statement, see below), executed on behalf of the patient by an interested person, e.g., a relative who may be available. If no interested person is available, the hospital administrator or his designee may execute the application. Only as much of the identifying information required in Items 1 through 5 on the form as is readily available should be completed. It is imperative, however, that the form show the hospitalized individual's name and that it be signed.

The number of instances when this procedure will be used will be quite limited. Supplies of form SSA-18 will be made available by the SSA district office. Larger hospitals will wish to obtain a small supply. Smaller hospitals, however, may find it preferable to prepare a statement to be signed by the interested party which would read as follows:

"I hereby apply on behalf of _____
_____ for all benefits payable under
the Social Security Act."

The application or statement should be mailed to the nearest SSA district office on the same day it is executed, since the postmark date will serve to establish the date of filing.

In the situation discussed above, a request for payment executed in accordance with § 271 would be appropriate.

310. NOTICE OF ADMISSION

When a patient 65 years or older is being admitted to the hospital for inpatient services, the hospital will complete the admission part of the inpatient hospital admission and billing forms. When signed, this represents the patient's request for payment of benefits (see §§ 270 ff.). There are two forms: SSA-1453, Inpatient Hospital Admission and Billing; and SSA-1485, Inpatient Psychiatric or Tuberculosis Hospital Admission and Billing. The bottom two copies of these forms are the admission copies. The top copies are retained for billing purposes, while the bottom copies may be detached and used in furnishing admission information to the intermediary.

Upon completion of the form furnish the notice of admission information to the intermediary (or to the appropriate Social Security Administration district office if the hospital deals with SSA). This information may be forwarded by mail, messenger, or telephone depending on the arrangements with the intermediary or the SSA district office.

The admission notice should not be forwarded before the first date a patient is actually entitled to hospital insurance benefits. If a patient enters the hospital before the month he becomes age 65, the admission notice should not be sent before the first day of the month of attainment.

310.1 Completing Inpatient Hospital Notice of Admission Form SSA-1453.—Use a typewriter for all entries on the forms, and show month, day, and year in 6-digit numbers, e.g., 07/01/66. (See Exhibit 4 for a sample of the inpatient admission notice.)

Item 1. Patient's Name. Enter the patient's name. It should be the same as that shown on his health insurance card with the last name first.

Item 2. Health Insurance Claim Number. Enter the patient's health insurance claim number shown on his health insurance card, utilization notice, or as reported by the social security district office.

Item 3. Patient's Address. Enter the patient's mailing address.

Item 4. Date of Birth. Enter the patient's date of birth.

Item 5. Sex. Enter "X" in the appropriate block.

Items 6 and 7. Hospital Identification. Enter the name and address of the hospital and the hospital's assigned health insurance provider number. This information may be preprinted on all copies of the hospital's supply of these forms.

Item 8. Medical Record No. Enter the patient's medical record number if one is assigned by the hospital

and the hospital needs it for association of files and referral.

Item 9. Attending Physician. Enter the name and address of the attending physician. The name should be that of the physician who is expected to certify and recertify the medical necessity of the hospital stay.

Item 10. Date of this Admission. Enter the date of this admission. Enter the actual date of admission even if before the effective date of entitlement to hospital insurance. For example, where a patient enters the hospital before July 1, 1966, enter the actual date of admission even though he is not entitled to hospital insurance before July 1, 1966, and the Notice of Admission would not be forwarded before that date.

Item 11. Prior Stay Information. Enter the name and address of any hospital (including your own) or extended care facility from which the patient says he was discharged as an inpatient within the last 60 days. If the patient has a Notice of Hospital Insurance Utilization showing a prior stay, give the dates shown. If the prior stay was in your hospital, enter "SAME" and the dates of the prior stay.

A recent prior admission or discharge may indicate whether the patient has limited or no eligibility in the current spell of illness, whether the \$40 inpatient or whole blood deductibles are applicable to this hospital stay, or whether the coinsurance provision will be in effect. Inpatient benefits are related to a spell of illness and, once begun, a spell of illness cannot end until an individual has **not** been an inpatient of a hospital or extended care facility for 60 consecutive days. An inpatient stay in a hospital or extended care facility continues a spell of illness and prevents the start of a new spell of illness with the current admission.

The information furnished by the hospital on the admission notice will be checked against the patient's central record and the intermediary's record. If further investigation is necessary, e.g., the date of prior discharge is not recorded on the patient's utilization record, or the prior-stay institution was a nonparticipating provider, the intermediary will verify the prior dates of stay.

Item 12. Payment Source. Enter an "X" in the appropriate check box(es) identifying who will pay for any services that cannot be paid for under the health insurance program. Where a public agency will pay any part of the patient's charges, show the name and address of the agency, and the patient's case number if it is available.

Item 13. Patient's Certification and Payment Request. Have the patient or his authorized representative read and sign this statement before the bill is submitted for payment.

If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf; e.g., John J. Jones by Jack A. Smith.

In certain situations, a hospital representative may sign on behalf of the patient. (See § 271 for who may file a payment request.)

Briefly explain the reason why the patient did not sign the form himself and show the relationship of the signer to the patient.

The statement should be read to the patient who signs by mark. The signature by mark should be witnessed by a person who knows the patient. Enter the name and address of any person witnessing the signature by mark.

Item 14. Admitting Diagnosis. Enter the admitting diagnosis as furnished by the physician. List the primary condition first. Enter an "X" in the checkbox to indicate whether or not the condition was employment related. If the condition is known to be employment related, show the name and address of the employer. (See §§ 289 ff. for effects of workmen's compensation involvement.)

310.2 Completing Admission Information on Inpatient Psychiatric or Tuberculosis Hospital Admission and Billing, Form SSA-1485.—The items on the admission portion of the form SSA-1485 are like those for the inpatient form, SSA-1453, except for items 10, 11, and 12. They are designed to identify the dates when an individual was receiving active treatment or necessary inpatient psychiatric diagnostic services in a participating hospital meeting the special requirements for psychiatric or tuberculosis hospitals. They also call for the special information needed to determine whether an inpatient stay in the 90-day period before the patient's entitlement to hospital insurance counts against the 90 days available to him in his first spell of illness. (See Exhibit 5.)

Item 10. Admitted for Active Care. This is the date the patient was admitted for active treatment or for a medically necessary inpatient psychiatric diagnostic study. This will ordinarily be the day on which the patient is admitted to the hospital or distinct part of the hospital which is equipped for such treatment or diagnostic services, even though the actual treatment or diagnostic procedures did not begin until a later date.

Item 11. Prior-Stay Information. Show the name and address of any hospital (including your own) or extended care facility in which the patient received care during the last 60 days. See the explanation of the effect of prior stays under item 11 of the inpatient notice of admission in § 310.1 above.

Where the patient was in your hospital, but not in the part of the hospital which has been certified as meeting the definition of a psychiatric or tuberculosis hospital, show "this hospital—stay before admission to active care from (date) to (date)."

Item 12. Name and Address of Any Psychiatric or Tuberculosis Institution Which Furnished In-

patient Services at Any Time During the 90-Day Period Preceding Effective Date for Hospital Insurance. This is the name and address of any psychiatric or tuberculosis institution which furnished inpatient services in the 90-day period preceding the patient's effective date for hospital insurance entitlement. The effective date of the patient's entitlement to hospital insurance is shown on his health insurance card. If the institution named is your own hospital:

(a) If it is a stay in your hospital or part of your hospital which meets the definition of a psychiatric or tuberculosis hospital, show "this hospital—from (date) to (date)."

(b) If the stay was in that part of your hospital which does not meet the definition of a psychiatric or tuberculosis hospital, show "this hospital—not for active care from (date) to (date)."

315. CONTENTS OF INTERMEDIARY REPLY TO NOTICE OF ADMISSION

The reply to the notice of admission will be furnished by the intermediary to the hospital according to prior arrangements. If the hospital deals directly with the Social Security Administration, it will receive a form reply to the notice of admission from Bureau of Health Insurance, Direct Reimbursement. The contents of the reply will be based on the intermediary's query of the SSA central record for eligibility information, and any necessary investigation of prior inpatient stays.

The "Report of Eligibility" part of the inpatient admission and billing forms (see Exhibit 4) may be used as a reply to the admission notice, where it is received by the intermediary as part of the admission notice. Whether the reply will be given by telephone, mail, or wire to the hospital, it will contain eligibility information similar to the content of the "Report of Eligibility" part of the admission notice. An explanation of the eligibility information in the "Report of Eligibility" is outlined below:

A. Effective Date—Hospital Insurance. The month, day, and year of the patient's entitlement to hospital insurance benefits (Part A) will be shown. If not entitled, the entry will so indicate.

B. Effective Date—Medical Insurance. This will show the month, day, and year of the patient's entitlement to medical insurance (Part B). The entry will so indicate if the patient is not entitled to Part B benefits.

C. Hospital Days Remaining. The number of inpatient days for which payment can be made in full will be shown in the "FULL" block. The number of inpatient days for which the patient is responsible for coinsurance payments will be shown in the "COINSURANCE" block.

D. Medical Plan Deductible. The status of this deductible will be indicated by a checkmark in the block

designated "MET" or "NOT MET." If the deductible is not met, the amount remaining to be met will not be shown.

E. Remaining Inpatient Deductible. The dollar amount of the \$40 inpatient deductible yet to be met for the current spell of illness will be shown. Where it has been met, "NONE," will be entered.

F. Pints Remaining—Blood Deductible. This will show the number of pints of blood needed to satisfy the whole blood deductible for the current spell of illness. Where applicable, "NONE" will be shown.

G. ECF Days Remaining. The number of inpatient extended care facility days available for the current spell of illness will be shown. Where applicable, "NONE" will be shown.

H. HHA Visits Remaining—Hospital Insurance and Medical Insurance. The number of home health visits remaining for hospital insurance will be shown. Medical insurance visits remaining will not be routinely shown in replying to hospital notices of admission.

I. Psychiatric Days Remaining. This information will be shown where the admitting hospital is a psychiatric hospital. It will show the number of days remaining toward the 190-day lifetime limitation on inpatient psychiatric services.

J. Open Item Information. The information in this block will be completed by the intermediary when verifying reports of open items (admissions recorded in SSA central records, but not closed out by processing of a bill).

Where there is an open item reported from the SSA central record to the intermediary or Bureau of Health Insurance, Direct Reimbursement, either the intermediary or the SSA district office will contact the "open item" provider to verify the stay, the date of the prior discharge, and status of the bill. The intermediary will use this information in computing the remaining days of eligibility.

Remarks. Any necessary explanation of eligibility information will be shown. This will include corrections in the name or health insurance claim number reported by the hospital. When changes of this sort are reported, the name and claim number information on the billing form should be changed accordingly.

If name and claim number information were not matched, the intermediary will request the hospital to check its record, or will contact the patient or the nearest district office to obtain a valid claim number.

The hospital may also be requested to verify reports of death shown in the patient's SSA central record.

320. RETROACTIVE ENTITLEMENT

When an application for social security benefits is filed by an individual over 65 years of age, he may inform the SSA district office that he received hospital services in the retroactive period of up to 12 months for which he may be entitled to benefits. Payment for the hospital services received in this period is possible.

The Social Security Administration certificate of award to the patient will contain a notice informing him to get in touch with the provider who furnished services. In these cases, follow the notice of admission procedure to obtain a report of eligibility from your intermediary before billing. If payment has been made to the hospital by the patient, the hospital should refund the appropriate amount to the patient.

325. INITIATING NOTICES OF ADMISSION WHERE PATIENT HAS EXHAUSTED BENEFITS PRIOR TO ADMISSION

Section 450 explains that hospitals will submit inpatient billing forms even when benefits are exhausted and no hospital payments under the program may be made. In most such cases, notices of admission will have been initiated as a normal course of hospital procedure to determine the patient's eligibility. However, there will be some situations where, at admission, the individual informs you that benefits have been exhausted in the current spell of illness, or he presents a Notice of Hospital Insurance Utilization which indicates this. The hospital should nevertheless initiate a notice of admission. This notice will serve to verify the information and assure that the patient has in fact no remaining eligibility.

The notice of admission is also essential for processing of the subsequent billing form which will be submitted in accordance with § 450.

399. EXHIBITS

Exhibit 1. Health Insurance Cards and Claim Numbers.


Exhibit 2. Notice of Hospital Insurance Utilization (Form SSA-1533).

Exhibit 3. Notice of Medical Insurance Utilization (Form SSA-1533a).


Exhibit 4. Inpatient Hospital Admission and Billing (Admission Copy)—Form SSA-1453.

Exhibit 5. Inpatient Psychiatric or Tuberculosis Hospital Admission and Billing (Admission Copy)—Form SSA-1485.

HEALTH INSURANCE CARDS

Health Insurance	
SOCIAL SECURITY ACT	
NAME OF BENEFICIARY JANE Q. DOE	
CLAIM NUMBER 000-00-0000B	SEX FEMALE
IS ENTITLED TO	
HOSPITAL INSURANCE	7-1-66
MEDICAL INSURANCE	7-1-66
SIGN HERE 	

Front

Health Insurance	
RAILROAD RETIREMENT BOARD	
NAME OF BENEFICIARY JOHN C. DOE	
CLAIM NUMBER A-000-00-0000	SEX MALE
IS ENTITLED TO	
HOSPITAL INSURANCE	7-1-66
MEDICAL INSURANCE	7-1-66
SIGN HERE 	

Front

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical or health services under "Medicare."
3. Get in touch with your social security office if you have questions about your rights under "Medicare."
4. Your card is good wherever you live in the United States.

WARNING: Issued for the sole use of the holder designated hereon. Intentional misuse of this card is unlawful and will make the offender liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT.
IF FOUND DROP IN NEAREST U.S. MAIL BOX.

Return To: SOCIAL SECURITY ADMINISTRATION
Baltimore, Maryland 21235

FORM SSA-1966 (7-66)

Back

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical or health services under "Medicare."
3. Get in touch with your Railroad Retirement Board office if you have questions about your rights under "Medicare."
4. Your card is good wherever you live in the United States. For benefits in Canada, write to the Railroad Retirement Board.

WARNING: Issued for the sole use of the holder designated hereon. Intentional misuse of this card is unlawful and will make the offender liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT.
IF FOUND DROP IN NEAREST U.S. MAIL BOX.

Return to: RAILROAD RETIREMENT BOARD
844 Rush Street, Chicago, Illinois 60611

Form G-43 (2-66)

Back

HEALTH INSURANCE CLAIM NUMBERS

Most HI claim numbers are 9 digits with a letter or letter and numeral suffix; e.g., 000-00-0000B or B1. They may also be 6-or-9-digit numbers with lettered prefixes; e.g., A000000, A-000-00-0000; or WD-000000, WD-000-00-0000. Numbers with one or more letter prefixes identify Railroad Retirement Board annuitants.

Possible suffixes are:

A, B, B1, B2, B3, B4, B5, B6, or B9.

C1, C2, C3, C4, or C5 (Suffixes higher than "5" are possible, but unlikely)

D, D1, D2, D3, D4, D5, D6, or D7

E, E1, E2, or E3

F1, F2, F3, F4, F5, F6, F7, or F8

HB, HB1, HB2, HB3, HB4, HB5, HB6, or HB9

HC1, HC2, HC3, HC4, or HC5

M, M1, and T (Suffix letter "T" indicates entitlement to hospital or hospital and medical insurance; letters M and M1 indicate that the patient is eligible for supplementary medical insurance benefits but not for hospital insurance benefits.)

EXHIBIT 2

Notice of Hospital Insurance Utilization, SSA-1533

FORM SSA-1533 (5-66)



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

NOTICE OF HOSPITAL INSURANCE UTILIZATION

NAME AND ADDRESS OF THE BENEFICIARY
OR REPRESENTATIVE OF THE BENEFICIARY

DATE:
HEALTH INSURANCE CLAIM NUMBER:

The bill for HOSPITAL INSURANCE services described below was recently submitted under your health insurance claim number and recorded to your account.

TYPE OF SERVICES	DATES COVERED BY BILL		NUMBER OF HOME HEALTH VISITS INCLUDED
	FROM	TO	

Institution or agency
providing services

Office which handled
your claim

For each spell of illness, your HOSPITAL INSURANCE under Medicare pays for the costs of all covered services, with certain exceptions. These are the exceptions for this bill:

RECORD OF ADDITIONAL BENEFITS AVAILABLE

As of the date of this notice, your record of inpatient hospital and extended care benefits for the spell of illness involved and home health benefits is as follows:

INPATIENT HOSPITAL DAYS			EXTENDED CARE FACILITY DAYS			HOME HEALTH VISITS		
USED THIS BILL	USED TO DATE	REMAINING	USED THIS BILL	USED TO DATE	REMAINING	USED THIS BILL	USED TO DATE	REMAINING

If you have to use HOSPITAL INSURANCE services again, please take this latest notice with you and show it, along with your Health Insurance card, to the agency or institution furnishing the services.

Robert M. Ball
Robert M. Ball
Commissioner of Social Security

PLEASE READ THE OTHER SIDE OF THIS NOTICE FOR IMPORTANT INFORMATION.

EXHIBIT 3

Notice of Medical Insurance Utilization, SSA-1533A

FORM SSA-1533A (5-66)



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

NOTICE OF MEDICAL INSURANCE UTILIZATION

NAME AND ADDRESS OF THE BENEFICIARY
OR REPRESENTATIVE OF THE BENEFICIARY

DATE:

HEALTH INSURANCE CLAIM NUMBER:

The bill for MEDICAL INSURANCE services described below was recently submitted under your health insurance claim number and recorded to your account.

TYPE OF SERVICES	DATES COVERED BY BILL		NUMBER OF HOME HEALTH VISITS INCLUDED
	FROM	TO	

Institution or agency
furnishing services }

Office which handled
your claim }

Each year, as soon as your covered medical expenses go over \$50, your MEDICAL INSURANCE will pay 80 percent of the reasonable costs or charges for all additional covered services for the rest of the year. The computation of MEDICAL INSURANCE benefits for this bill is shown below.

TOTAL COVERED CHARGES	AMOUNT TOWARD \$50 DEDUCTIBLE	20% PAYABLE BY BENEFICIARY	TOTAL PAYABLE BY BENEFICIARY
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STATUS OF MEDICAL INSURANCE RECORD

As of the date of this notice, the status of your MEDICAL INSURANCE record is as follows:

Robert M. Ball
Robert M. Ball

Commissioner of Social Security

PLEASE READ THE OTHER SIDE OF THIS NOTICE FOR IMPORTANT INFORMATION.


EXHIBIT 4

The Admission Copy of the Inpatient Hospital Admission and Billing form.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE SOCIAL SECURITY ADMINISTRATION			INPATIENT HOSPITAL ADMISSION AND BILLING HOSPITAL INSURANCE BENEFITS—SOCIAL SECURITY ACT		Form Approved Budget Bureau No. 72-R734
1. PATIENT'S LAST NAME Public		FIRST NAME John		MI Q	2. HEALTH INSURANCE CLAIM NUMBER 000-00-0000A
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code) 3405 Redman Rd., Pittsburgh, Pennsylvania 15219					4. DATE OF BIRTH 0 1 1 2 9 2
6. HOSPITAL NAME AND ADDRESS Pittsburgh General Hospital North Avenue Pittsburgh, Pa. 15219					5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F
7. PROVIDER NO. 000000					9. NAME AND ADDRESS OF ATTENDING PHYSICIAN John C. Doe, M.D. 664 Marine Ave. Pittsburgh, Pa. 15219
8. MEDICAL RECORD NO.					
10. DATE OF THIS ADMISSION 0 2 1 2 6 7		11. NAME AND ADDRESS OF ANY INSTITUTION FROM WHICH DISCHARGED DURING LAST 60 DAYS (If this hospital, give dates of stay) None			
12. PAYMENT SOURCE FOR CHARGES TO PATIENT					
<input checked="" type="checkbox"/> SELF OR FAMILY <input type="checkbox"/> BLUE CROSS <input type="checkbox"/> PUBLIC AGENCY <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> BLUE SHIELD (Give name) <input type="checkbox"/> <input type="checkbox"/> EMPLOYER OR UNION <input type="checkbox"/> OTHER (Explain)					
13. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.					
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed) <i>John G. Public</i>					DATE 02/12/67
14. ADMITTING DIAGNOSIS Arteriosclerotic Heart Disease		EMPLOYMENT RELATED <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		If yes, give name and address of employer	
REPORT OF ELIGIBILITY					
A. Effective Date - Hospital Insurance		07/01/66		J. Open Item Information 1. Intermediary	
B. Effective Date - Medical Insurance		07/01/66			
C. Hospital Days Remaining		Full 60	Coinsurance 30		
D. Medical Plan Deductible		<input type="checkbox"/> Met	<input checked="" type="checkbox"/> Not Met		
E. Remaining inpatient Deductible \$		\$40.00		2. Provider	
F. Pints Remaining Blood Deductible		3			
G. ECF Days Remaining		100			
H. HHA Visits remaining		Hospital Insurance 100	Medical Insurance		
I. Psychiatric Days Remaining				3. Date Admitted	
Remarks					
				4. Date Discharged	
Intermediary Approval <i>John A. Dandaga</i>					Date 02/16/67

EXHIBIT 5

The Admission Copy of the Inpatient Psychiatric or Tuberculosis Hospital Admission and Billing Form.

 DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE SOCIAL SECURITY ADMINISTRATION			INPATIENT PSYCHIATRIC OR TUBERCULOSIS HOSPITAL ADMISSION AND BILLING HOSPITAL INSURANCE BENEFITS - SOCIAL SECURITY ACT		Form Approved. Budget Bureau No. 72-R732
1. PATIENT'S LAST NAME Public		FIRST NAME Jane		MI C.	2. HEALTH INSURANCE CLAIM NUMBER 000-00-0000B
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code) 4309 Loxkel Dr., Dallas, Texas 75201			4. DATE OF BIRTH 1 1 1 7 9 0		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F
6. HOSPITAL NAME AND ADDRESS Farm Oak Hospital Farm Oak Street Dallas, Texas 75201		7. PROVIDER NO. 000000		9. NAME AND ADDRESS OF ATTENDING PHYSICIAN Dr. Casey Q. Doe 3 Medical Towers Ave. Dallas, Texas 75201	
8. MEDICAL RECORD NO.					
10. ADMITTED TO ACTIVE CARE 1 1 1 3 6 7		11. NAME AND ADDRESS OF ANY INSTITUTION (including this institution) IN WHICH PATIENT RECEIVED INPATIENT CARE DURING LAST 60 DAYS (If this hospital, give dates of stay) Texas General Hospital, Orange St., Dallas, Texas 75201			
12. NAME AND ADDRESS OF ANY PSYCHIATRIC OR TUBERCULOSIS INSTITUTION WHICH FURNISHED INPATIENT SERVICES AT ANY TIME DURING 90 DAY PERIOD PRECEDING EFFECTIVE DATE FOR HOSPITAL INSURANCE (If this hospital, give dates of stay) None					
13. PAYMENT SOURCE FOR CHARGES TO PATIENT					
<input checked="" type="checkbox"/> SELF OR FAMILY <input type="checkbox"/> BLUE CROSS <input type="checkbox"/> PUBLIC AGENCY <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> BLUE SHIELD (Give name) <input type="checkbox"/> EMPLOYER OR UNION <input type="checkbox"/> OTHER (Explain)					
14. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.					
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed) <i>Jane C. Public by John G. Public, husband</i>				Patient unable to sign due to mental condition. DATE 11/13/67	
15. ADMITTING OR CURRENT DIAGNOSIS EMPLOYMENT RELATED <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, give name and address of employer.)					
Schizophrenia, Simple					
REPORT OF ELIGIBILITY					
A. Effective Date - Hospital Insurance		07/01/66		J. Open Item Information 1. Intermediary	
B. Effective Date - Medical Insurance		07/01/66			
C. Hospital Days Remaining		Full 40	Coinsurance 30		
D. Medical Plan Deductible		<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met			
E. Remaining Inpatient Deductible		\$ None			
F. Pints Remaining Blood Deductible		None			
G. ECF Days Remaining		100		2. Provider	
H. HHA Visits Remaining		Hospital Insurance 100	Medical Insurance		
I. Psychiatric Days Remaining		190			
Remarks					
				3. Date Admitted	
				4. Date Discharged	
INTERMEDIARY APPROVAL <i>Forster O'Leary</i>				DATE 11/17/67	

Chapter IV

BILLING PROCEDURES

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**INPATIENT HOSPITAL ADMISSION AND BILLING
HOSPITAL INSURANCE BENEFITS—SOCIAL SECURITY ACT**

Form Approved
Budget Bureau
No. 72-R734

1. PATIENT'S LAST NAME			FIRST NAME		MI	2. HEALTH INSURANCE CLAIM NUMBER			
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)						4. DATE OF BIRTH		5. SEX <input type="checkbox"/> M <input type="checkbox"/> F	
6. HOSPITAL NAME AND ADDRESS				7. PROVIDER NO.		9. NAME AND ADDRESS OF ATTENDING PHYSICIAN			
				8. MEDICAL RECORD NO.					
10. DATE OF THIS ADMISSION			11. NAME AND ADDRESS OF ANY INSTITUTION FROM WHICH DISCHARGED DURING LAST 60 DAYS (If this hospital, give dates of stay)						
12. PAYMENT SOURCE FOR CHARGES TO PATIENT									
<input type="checkbox"/> SELF OR FAMILY			<input type="checkbox"/> BLUE CROSS BLUE SHIELD			<input type="checkbox"/> PUBLIC AGENCY (Give name)			
<input type="checkbox"/> PRIVATE INSURANCE			<input type="checkbox"/> EMPLOYER OR UNION			<input type="checkbox"/> OTHER (Explain)			
13. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.									
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)								DATE	
14. ADMITTING DIAGNOSIS				EMPLOYMENT RELATED		<input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, give name and address of employer	
15. DISCHARGE DIAGNOSES OR CURRENT DIAGNOSES (Primary illness and secondary or complicating illnesses)								Do not use this space	
16. SURGICAL PROCEDURES (Related to primary illness and other—Show date of each)									
17. STATEMENT OF SERVICES RENDERED				TOTAL CHARGES		NON-COVERED CHARGES		18. STATEMENT COVERS PERIOD	19. TOTAL DAYS
ACCOMMODATION		DAYS	RATE					FROM	TO
A. 1-Bed				\$		\$			
B. 2-3-4 Bed									
C. 5 or more Beds									
D. Intensive Care									
E. Self Care									
F. WHOLE BLOOD	PINTS FURNISHED	NOT REPLACED	CHARGE PER PINT					20. DATE GUARANTEE OF PMT. OR UR NOTICE RECEIVED	21. DATE BENEFITS EXHAUSTED
G. Operating Room								22. <input type="checkbox"/> DISCHARGED	23. DATE DISCHARGED OR DIED
H. Pharmacy								<input type="checkbox"/> DIED <input type="checkbox"/> STILL PATIENT	
I. Laboratory									
J. Radiology									
K. Medical, Surgical and Central Supplies									
L. Anesthesia									
M. Inhalation Therapy									
N. Other (Describe)									
O. TOTALS				\$		\$		24. COMPUTATION OF INTERIM PAYMENT	
P. Inpatient Deductible								Reimbursement Amount \$	
Q. Blood deductible Pts. @								FOR INTERMEDIARY USE	
R. Coinsurance								25. VERIFIED PRIOR STAY DATES	
S. TOTAL DEDUCTIONS								PROVIDER NO.	
I certify that the required physician's certification and recertifications are on file.								26. SIGNATURE OF HOSPITAL REPRESENTATIVE	
				DATE FORWARDED		27. APPROVED BY		DATE	

Chapter IV

BILLING PROCEDURES

400. BILLING PROCEDURES—GENERAL

The forms used for billing under the hospital insurance program are:

SSA-1453—Inpatient Hospital Admission and Billing.

SSA-1485—Inpatient Psychiatric or Tuberculosis Hospital Admission and Billing.

SSA-1483—Outpatient Hospital Billing.

The hospital may also have occasion to use Form SSA-1554, Provider Billing for Patient Services by Physicians, where the hospital has been authorized by a physician to bill on his behalf and also Form SSA-1484, Explanation of Accommodation Furnished, where an accommodation other than two, three, or four beds was furnished.

Form SSA-1453 will be used to bill for inpatient services in a participating hospital unless the hospital meets the special qualifications for a psychiatric or tuberculosis hospital described in §§ 204 and 203. If inpatient care is given for a psychiatric or tubercular condition in a general hospital the form SSA-1453 is used. SSA-1485, Inpatient Psychiatric or Tuberculosis Hospital Admission and Billing is used by a hospital meeting the special requirements for participation as a psychiatric or tuberculosis hospital. The Outpatient Hospital Billing, Form SSA-1483, will be used to bill for outpatient services whether such services are covered under hospital or medical insurance. Sometimes a patient will be admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient before midnight of the day after the day outpatient services were rendered, all services will be considered inpatient services for billing purposes. The day of formal admission as an inpatient will be considered as the first day of inpatient hospital services. If the hospital maintains an ambulance service, and the use of an ambulance met the requirements described in § 240.6 the ambulance would be billed on form SSA-1483.

Where a psychiatric or tuberculosis hospital maintains an outpatient department, services will likewise be billed only on Form SSA-1483, Outpatient Hospital Billing.

Where the hospital maintains a home health services department, billing for services from this department should be made on Form SSA-1487, Home Health Agency Report and Billing. Instructions for the completion of this form are contained in the Home Health Agency Manual.

A billing form should be submitted even where the patient is responsible for a deductible which covers the entire amount of the hospital charges. This is required both for inpatient and outpatient situations.

400.1 List of Authorized Signatories.—Each hospital should submit to its Part A intermediary a listing of officials it has authorized to sign and certify bills and supporting statements. The listing should be kept current.

402. INPATIENT HOSPITAL ADMISSION AND BILLING (FORM SSA-1453)

This form serves two purposes. It is used to report the admission of a patient who is eligible for hospital insurance so that the Social Security Administration and the hospital's intermediary can determine how many benefit days are available. It is also used to bill the intermediary for the payment due the hospital for the services rendered.

The bottom two copies of the form can be used to report the admission. (The procedures for reporting admissions are described in the Admission Procedures Chapter.) The hospital fills out items 1 through 14 of all copies of the form, **detaches the bottom two copies**, and notifies the intermediary in accordance with its usual procedures. (If the two copies allotted for admission notification are not used for this purpose, they may be destroyed.)

The instructions for using the Report of Eligibility portion of the admission copies to determine the number of days for which payment may be made and any deductibles for which the patient is responsible are contained in § 315.

Items 15 through 26 of the billing form should be completed at the time the bill is rendered. The bill may be rendered at the time the patient is discharged or after his benefits are exhausted. It also may be submitted on an interim basis.

A billing form should be submitted even where the patient is responsible for a deductible which covers the entire amount of the hospital charge. It should also be submitted for periods after benefits are exhausted. The submission of billing forms for periods where there is no payment due the hospital will enable the Social Security Administration and the intermediary to maintain a correct current record of deductibles and days available. It is not, however, necessary to complete all the items on a form if it is being submitted for a period after benefits have been exhausted. The procedure for completing and submitting forms after benefits have been exhausted is described in § 450.

402.1 Completion of Billing Items on the Form SSA-1453

Item 15. Current or Discharge Diagnoses. Enter here all of the diagnoses shown on the face sheet or discharge sheet of the patient's hospital record which relate to the condition requiring the current hospitalization. The primary diagnosis should appear first. This is the diagnosis of the illness or condition which was the primary reason for the patient's hospitalization. Identify this primary diagnosis by writing the word "primary" in parentheses. Any remaining diagnoses should be listed in the same order in which they appear on the face sheet or discharge sheet. The diagnosis should be shown in accordance with recognized nomenclature, e.g., *Current Medical Terminology*, *Standard Nomenclature of Diseases and Operations*.

Item 16. Surgical Procedures. Surgical procedures should be specified in detail using recognized nomenclature such as that used in *Current Medical Terminology*, *Standard Nomenclature of Diseases and Operations*, etc. For the purposes of this form, surgery includes incision, excision, amputation, introduction, endoscopy, repair, destructions, suture, and manipulations.

Enter the name of the procedures, if any, shown on the face sheet or discharge sheet of the patient's hospital record which were performed during the period covered by the bill. Show the dates of each operation or endoscopic procedure listed. List first those procedures related to the primary diagnosis. List all other operation and endoscopic procedures in the same order as is shown on the face sheet or discharge sheet.

Item 17. Statement of Services. If the hospital and the intermediary agree, the hospital may use columnar ledger sheets to report services and charges. In such cases the hospital need not complete item 17 except for the accommodation and blood entries. Where ledger sheets are submitted in lieu of item 17, each ledger sheet attached should show the patient's claim number. Charges for services which are not covered should be fully identified either on the ledger sheet attached or in the "Noncovered Charges" column of item 17.

Show all charges for the period covered by the current billing for each of the departments. Where your hospital has more departments than shown on the form, combine the charges, where appropriate, for the purpose of completing the form. Any charge which cannot be applied to one of the items shown should be described in 17N-Other. Show all charges—covered and noncovered—in the "Total Charges" column. Charges for noncovered services and items, except for the services of hospital-based physicians, are itemized in the "Noncovered Charges" column. If it is necessary to explain an item, a statement may be attached. Any statement attached should show the patient's name and claim number. Details concerning coverage, deductibles, and coinsurance are contained in Chapter II.

ACCOMMODATION

A. One bed. Where a patient needed a private room for medical reasons, complete and attach one copy of form SSA-1484 to explain the medical necessity. Enter the customary charge for a one-bed accommodation in the "Rate" column and complete the "Total Charges" column.

If the patient was in a one-bed accommodation for other than medical reasons, payment cannot be made for more than the most prevalent two-, three-, or four-bed accommodation rate. In such cases an SSA-1484 will not be required and the charge for the one-bed accommodation should be entered in the "Rate" column. Show the difference between the total one-bed room charges and the accommodation charges which would have been made if the patient had occupied a two-, three-, or four-bed room (at the most prevalent rate for such a room at the time of admission) in the "Noncovered Charges" column.

B. Two-, three-, or four-bed. If the patient occupies semiprivate accommodations (two-, three-, or four-bed room), show the number of days and the actual daily rate for the accommodations.

C. Five or more beds. Under the hospital insurance program, payment is made for semiprivate accommodations (two-, three-, or four-bed room). If the patient is assigned to a room with five or more beds, the hospital should complete Form SSA-1484, Explanation of Accommodation Furnished, in duplicate, explaining the reasons for this accommodation, and attach these forms to the billing form. If the patient requested the assignment, only one copy of the SSA-1484 is necessary. (See § 412 for instructions on use of Form SSA-1484 and completion of items.) Where the patient requested a five or more bed assignment, or the reason for assignment is one that the intermediary can approve, the reimbursement will be made for the reasonable costs of the actual accommodation furnished. However, where the ward accommodation was provided

not at the patient's request, nor for a reason which the intermediary can approve, payment will be made, at the end-of-the-year settlement, on the basis of the reasonable cost of semiprivate accommodations minus the difference between the hospital's customary charge for semiprivate accommodations and its customary charge for ward accommodations. In either case, the customary ward charge should be shown in the "Rate" column on the billing form. But when the ward accommodation was not requested by the patient or approved by the intermediary, the hospital should show its customary charge for semiprivate accommodations, at the most prevalent rate at the time the accommodation was made, on the Form SSA-1484, so that the intermediary can compute the payment due.

D. and E. Intensive care and self-care. Show the number of days the patient was in an intensive and/or self-care unit, applicable rate, and total charges.

The total number of days in the various accommodations shown on the form should equal the total number of days shown in item 18. Where some of the days cannot be paid for because benefits were exhausted before discharge or death, show the charges for days after benefits were exhausted under "Noncovered Charges."

F. Whole blood. The report of eligibility from your intermediary (or from the Social Security Administration if you deal directly) will show the number of pints of whole blood which the patient is responsible for replacing or paying for. If the patient has already replaced or been charged for three pints of blood in this spell of illness, no further blood deductible is applicable.

G.-O. General. Item G includes recovery room and item H includes intravenous solution.

Where items and services are furnished which are more expensive or in excess of the services covered by the program, the difference between the amount customarily charged for such services requested and the amount customarily charged for covered services should be shown as noncovered charges. An example of this would be luxury meals at extra cost.

P. Inpatient deductible. The amount of the deductible which is applicable is shown on the report of eligibility received in response to the Notice of Admission.

The amount to be shown in this item is \$40, unless the entire covered charge for the stay is less than \$40, or unless the patient had previously met some or all of the deductible amount in this spell of illness. Where the total charge for the bill is not equal to \$40, show the full actual charge in item 17-P. Where the patient has previously met part or all of the deductible in the spell of illness, show any remaining deductible.

Q. Blood deductible. Show the amount charged (excluding any charge for blood administration) to the patient for the first three pints unless the patient has previously met all or part of the blood deductible in this spell of illness. Where the patient has met part of the blood deductible during a prior stay in the same spell of illness, determine the remaining blood deductible from the reply to the Notice of Admission and enter it in this item.

R. Coinsurance. The coinsurance days are the 61st day through the 90th day. Multiply the number of days by \$10 and show that amount in the "Noncovered Charges" column.

S. Total deductions. Show the total of any amount appearing in items P through R.

Item 18. Statement Covers Period. Show the beginning and ending days of the period covered by the bill. However, the beginning date should be no earlier than the first day of the beneficiary's date of entitlement even though the date of admission in item 10 may be before that date. Where the patient was admitted before July 1, 1966, show 07/01/66 in the "From" item. In the "To" item, show the date of death or discharge.

Where the patient is still in the hospital, show the last day of the period being reported on the bill, whether or not this last day was a day of covered service.

See § 450 for completion of the form after benefits have been exhausted.

Item 19. Total Days. Show the total days of covered inpatient care.

Exclude any days for which payment may not be made because benefits were exhausted. In counting days, count the date of admission but do not count the date of discharge.

Item 20. Date Guarantee of Payment or UR Notice Received. Use this section to report either of the following:

A. The date that the hospital received the report of eligibility showing that the number of inpatient days remaining was less than the number of inpatient days already provided in the current hospitalization.

B. The date of receipt by the hospital of the finding by the physician members of the Utilization Review Committee (or the group responsible for review of utilization) that a further hospital stay was not medically necessary.

Cross out the item which does not apply.

The guarantee of payment provision does not apply unless the hospital establishes that it acted in good faith in assuming the individual was entitled to have payment made for hospital services, and acted reasonably in assuming that the patient's inpatient days had not been and were not about to be exhausted. See § 286

INPATIENT PSYCHIATRIC OR TUBERCULOSIS HOSPITAL ADMISSION AND BILLING
HOSPITAL INSURANCE BENEFITS - SOCIAL SECURITY ACTForm Approved.
Budget Bureau
No. 72-R732

1. PATIENT'S LAST NAME			FIRST NAME		MI	2. HEALTH INSURANCE CLAIM NUMBER			
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)						4. DATE OF BIRTH		5. SEX <input type="checkbox"/> M <input type="checkbox"/> F	
6. HOSPITAL NAME AND ADDRESS				7. PROVIDER NO.		9. NAME AND ADDRESS OF ATTENDING PHYSICIAN			
				8. MEDICAL RECORD NO.					
10. ADMITTED TO ACTIVE CARE			11. NAME AND ADDRESS OF ANY INSTITUTION (including this institution) IN WHICH PATIENT RECEIVED INPATIENT CARE DURING LAST 60 DAYS (If this hospital, give dates of stay)						
12. NAME AND ADDRESS OF ANY PSYCHIATRIC OR TUBERCULOSIS INSTITUTION WHICH FURNISHED INPATIENT SERVICES AT ANY TIME DURING 90 DAY PERIOD PRECEDING EFFECTIVE DATE FOR HOSPITAL INSURANCE (If this hospital, give dates of stay)									
13. PAYMENT SOURCE FOR CHARGES TO PATIENT <input type="checkbox"/> SELF OR FAMILY <input type="checkbox"/> BLUE CROSS BLUE SHIELD <input type="checkbox"/> PUBLIC AGENCY (Give name) <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> EMPLOYER OR UNION <input type="checkbox"/> OTHER (Explain)									
14. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.									
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)								DATE	
15. ADMITTING OR CURRENT DIAGNOSIS EMPLOYMENT RELATED <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, give name and address of employer.)									
16. DISCHARGE DIAGNOSES OR CURRENT DIAGNOSES (Primary illness and secondary or complicating illnesses)								Do Not Use This Space	
17. SURGICAL PROCEDURES (Related to primary illness and other—Show date of each)									
STATEMENT OF SERVICES RENDERED			TOTAL CHARGES		NON-COVERED CHARGES		19. STATEMENT COVERS PERIOD FROM TO		20. TOTAL DAYS
ACCOMMODATION			DAYS	RATE					
A. 1-Bed					\$				
B. 2-3-4 Bed							21. DATE ACTIVE CARE ENDED		
C. 5 or more Beds									
D. Intensive Care							CONTINUING		
E. Self Care							<input type="checkbox"/>		
F. WHOLE BLOOD		PINTS FURNISHED	NOT REPLACED	CHARGE PER PINT			22. DATE GUARANTEE OF PMT. OR UR NOTICE RECEIVED		23. DATE BENEFITS EXHAUSTED
G. Operating Room									
H. Pharmacy							24. <input type="checkbox"/> DISCHARGED		25. DATE DISCHARGED OR DIED
I. Laboratory							<input type="checkbox"/> DIED <input type="checkbox"/> STILL PATIENT		
J. Radiology							26. COMPUTATION OF INTERIM PAYMENT		
K. Medical, Surgical and Central Supplies									
L. Anesthesia									
M. Inhalation Therapy									
N. Other (Describe)									
O. TOTALS					\$		Reimbursement Amount \$		
P. Inpatient Deductible							FOR INTERMEDIARY USE		
Q. Blood Deductible Pts. @							27. VERIFIED PRIOR STAY DATES		PROVIDER NO.
R. Coinsurance							<input type="checkbox"/> NONE FROM TO		
S. TOTAL DEDUCTIONS							DAYS USED		
I certify that the required physician's certification and recertifications are on file.									
28. SIGNATURE OF HOSPITAL REPRESENTATIVE					DATE FORWARDED		29. APPROVED BY		DATE

for an explanation of the guarantee of payment provision.

Where the guarantee of payment provision applies, the hospital should attach a statement indicating why it believes that the requirements of this provision are met.

Item 21. Date Benefits Exhausted. If the patient is still hospitalized and no further days are available, show the last day for which the benefits were payable. No entry should be made in this space when the Reply to the Notice of Admission showed that no days are available.

Items 22 and 23. Discharge Information. If the patient is still hospitalized when the billing is submitted, check "Still Patient." Otherwise check "Discharged" or "Died" in item 22. Show the date of discharge or death in item 23.

Item 24. Computation of Interim Payment. Payments to the hospital under the hospital insurance plan are based on the reasonable cost of services provided.

The precise reasonable cost of services cannot be determined until the end of the year when final cost figures are known. An interim settlement is made on the basis of each bill however. This interim settlement method will be established by the intermediary on the basis of the hospital's previous cost experience. The hospital may wish to make a computation on its own copy of the form. If the hospital wishes to make a computation for its own records it can estimate the cost of covered services by the approved method and subtract the applicable deductible and coinsurance to arrive at the reimbursement amount.

Item 25. Verified Prior Stay Dates and Provider Number.—DO NOT USE.

Item 26. Hospital Certification and Signature Line.—A hospital representative should make sure that the required physician's certification and recertifications are in the hospital records. The representative should then sign and date the form before it is submitted to the intermediary.

Item 27. Approved By and Date.—DO NOT USE.

402.2 Disposition of Copies of Completed Forms SSA-1453.—Retain the copy designated "Hospital Copy" and submit the remaining copies to your intermediary (or SSA in direct dealing situations). The remaining copies to be submitted to the intermediary or SSA constitute the following:

a. The original copy which is maintained in the intermediary's (or Social Security's) files.

b. One copy designated "Social Security Administration Copy."

c. The copy designated "Carrier Copy." The intermediary will send this copy to the intermediary processing physicians' bills.

410. INPATIENT PSYCHIATRIC OR TUBERCULOSIS ADMISSION AND BILLING (FORM SSA-1485)

Payment may be made to a psychiatric hospital for inpatient services when a physician certifies these services are required and can be expected to improve the patient's condition, or for an inpatient diagnostic study which the physician certifies is required.

Payment may be made to a tuberculosis hospital for inpatient services when a physician certifies that these services are required, and that the treatment can be expected to improve the patient's condition or render it noncommunicable.

No payment can be made for psychiatric or tuberculosis inpatient hospital services unless the patient is receiving active or intensive care.

The procedures for reporting admissions are described in Chapter III. The hospital fills out items 1 through 15 of all copies of the form, detaches the bottom two copies, and notifies the intermediary in accordance with its usual procedures. The instructions for using the report of eligibility to determine the number of days for which payment may be made, and any deductibles for which the patient is responsible are contained in § 315.

Items 15 through 26 of the billing form should be completed at the time the bill is rendered. The bill may be rendered at the time the patient is discharged or after his benefits are exhausted. It also may be submitted on an interim basis in long-stay cases.

a. A billing form should be submitted even where the patient is responsible for a deductible which covers the entire amount of the hospital charge. It should also be submitted after the patient's discharge even if it covers only a period after benefits are exhausted. The submission of billing forms for periods where there is no payment due the hospital will enable the Social Security Administration and the intermediary to maintain a correct current record of deductibles and days available. It is not, however, necessary to complete all the items on a form if it is being submitted for a period after benefits have been exhausted. The procedure for completing and submitting forms after benefits have been exhausted is described in § 450.

b. Where inpatients of a hospital (including a psychiatric or tuberculosis hospital) or of an extended care facility leave the hospital for planned leaves of absence or where they are absent without leave, the following rules apply in determining which days are to be counted as inpatient days.

(1) **Patient Does Not Return to Hospital by Midnight of the Same Day.**—Where an inpatient leaves a hospital on a given day and does not return by midnight of the same day, such day is treated as a day of discharge.

(2) **Patient Returns to Hospital.**—The day on which a patient returns to a hospital following a leave of absence is treated as an inpatient day if he is lodged in the hospital at midnight of that day.

410.1 Completion of Billing Items on the Form SSA-1485.

Item 16. Current or Discharge Diagnoses.—Enter here all of the diagnoses shown on the face sheet or discharge sheet of the patient's hospital record. Only diagnoses relating to the condition requiring the current hospitalization are necessary. The primary diagnosis should appear first. This is the diagnosis of the illness or condition which was the primary reason for the patient's hospitalization. Identify this primary diagnosis by writing the word "primary" in parentheses after the diagnosis. Any remaining diagnoses should be listed in the same order in which they appear on the face sheet or discharge sheet.

Item 17. Surgical Procedures.—Surgical procedures should be specified in detail using recognized nomenclature such as that used in *Current Medical Terminology*, *Standard Nomenclature of Diseases and Operations*, or *American Psychiatric Association's Diagnostic and Statistical Manual*, etc. For the purposes of this form, surgery includes incision, excision, amputation, introduction, endoscopy, repair, destructions, suture, and manipulations. Enter the name of the procedures, if any, shown on the face sheet or discharge sheet of the patient's hospital record which were performed during the period covered by the bill. Show the dates of each operation or endoscopic procedure listed. List first those procedures related to the primary diagnosis. List all other operation and endoscopic procedures in the same order as is shown on the face sheet or discharge sheet.

Item 18. Statement of Services.—If the hospital and the intermediary agree, the hospital may use columnar ledger sheets to report services and charges. In such cases, the hospital need not complete item 18 except for the accommodation and blood entries. When ledger sheets are attached in lieu of item 18, each sheet attached should show the patient's claim number. Charges for services which are not covered should be fully identified either on the ledger sheet attached or in the noncovered charges column of item 18.

Any charge which cannot be applied to one of the items shown should be described in 17N—Other. Show all charges—covered and noncovered—in the total charges column. Charges for noncovered services and items are itemized in the noncovered charges column. The services of hospital-based physicians are *not* included in noncovered charges for the purpose of this form. If it is necessary to explain an item, a statement may be attached. Any statement attached should show the patient's name and claim number.

ACCOMMODATION

The total number of days in the various accommodations shown on the form should equal the total number of days shown in item 20. Where some of the days cannot be paid for because benefits were exhausted, show the charges for these days under "Noncovered Charges."

A. *One bed.* Where a patient needed a private room for medical reasons complete and attach one copy of Form SSA-1484, Explanation of Accommodation Furnished, to explain the medical necessity. (See § 412 for instructions on use of Form 1484 and completion of items.) Enter the customary charge for a one-bed accommodation in "Rate" column, and fill in the "Day" and the "Total Charges" columns. If the patient was in a one-bed accommodation for other than medical reasons, payment cannot be made for more than the most prevalent two-, three-, or four-bed accommodation charge. In this case, show the difference between the total one-bed room charges and the most prevalent rate for semiprivate accommodations in the "Noncovered Charges" column.

B. *Two-, three-, or four-bed.* If the patient occupies semiprivate accommodations (two, three, or four beds), show the number of days and the actual daily rate for the accommodations.

C. *Five or more beds.* Under the hospital insurance program, payment is made for semiprivate accommodations (two-, three-, or four-bed room). If the patient is assigned to a room with five or more beds the hospital should complete Form SSA-1484, Explanation of Accommodation Furnished, in duplicate, explaining the reasons for this accommodation, and attach these forms to the billing form. If the patient requested the assignment, only one copy of the SSA-1484 is necessary. (See § 412 for use and completion of Form SSA-1484.)

Where the patient requested a five or more bed assignment, or the reason for assignment is one that the intermediary approves, the reimbursement will be made for the reasonable costs of the actual accommodation furnished. However, where the ward accommodation was provided **not** at the patient's request, nor for a reason which the intermediary approves, payment will be made, at the end-of-the-year settlement, on the basis of the reasonable cost of semiprivate accommodations minus the difference between the hospital's customary charge for semiprivate accommodations and its customary charge for ward accommodations. In either case, the customary ward charge should be shown in the "Rate" column on the billing form. But when the ward accommodation was not requested by the patient or approved by the intermediary, the hospital should show its customary charge for semiprivate accommodations at the most prevalent rate at the time the

accommodation was made on the Form SSA-1484, so that the intermediary can compute the payment due.

D. and E. *Intensive Care and Self-Care.* If the patient was in an intensive and/or self-care unit show the number of days, applicable rate, and total charges. Intensive care and self-care, as used here, have their usual medical meanings as special accommodations for acutely ill patients or patients requiring minimal care.

F. *Whole Blood.* The report of eligibility which you received from your intermediary will state the number of pints of whole blood for which the patient is responsible for replacement or payment. If the patient has already replaced or been charged for three pints of blood in this spell of illness, he should not be asked to pay any blood deductible.

G.-N. *General.* Item G includes recovery room and item H includes intravenous solution.

Where items and services more expensive or in excess of those covered by the hospital insurance program are furnished, the difference between the amount customarily charged for the items or services requested and the amount customarily charged for the items and services **covered by the program** should be shown as noncovered charges. An example of this would be luxury meals at extra cost.

P. The amounts of the deductibles which are applicable are contained on the report of eligibility which was received in response to your Notice of Admission.

Inpatient Deductible

The amount to be shown in this item is \$40 unless the entire covered charge for the stay is less than \$40 or unless the patient had previously met some or all of the deductible amount in this spell of illness. Where the total charge for the bill is not equal to \$40, show the actual full charge. Where the patient has previously met part or all of the deductible in the spell of illness show any remaining deductible.

Q. *Blood Deductible.* Show the amount charged (excluding any charge for blood administration) to the patient for the first three pints of whole blood furnished in the patient's spell of illness. If the patient has paid for or replaced any blood in a previous inpatient stay during the current spell of illness, the remaining deductible will be shown on the Reply to the Notice of Admission.

R. *Coinsurance.* The coinsurance provision applies to the 61st through the 90th day of hospital days in a spell of illness. Multiply the days in this period by \$10 and show the result in the "Noncovered Charges" column.

If a patient was receiving care in a qualified psychiatric or tuberculosis hospital, or distinct part of a psychiatric or tuberculosis hospital, in the 90 days before his entitlement to hospital insurance, these days may count against the 90 days available in a spell of

illness. However, they do not count toward the 190-day limit on inpatient psychiatric hospital services. Also, for the purpose of figuring when coinsurance first applies, **the inpatient psychiatric or tuberculosis hospital days** before entitlement are not counted. (See § 225 for a discussion and example of this provision.)

Item 19. Statement Covers Period. Show the beginning and ending days of the period covered by the bill. However, the beginning date should be no earlier than the first day of the beneficiary's date of entitlement even though the admission to active care in item 10 may be before that date. Where the patient was admitted before July 1, 1966, show 07/01/66 in the "From" item. In the "To" item, show the date of death or discharge when the patient is no longer in the hospital. When the patient is still in the hospital, show the last day of the period being reported on the bill whether or not this last day was a day of covered service.

Item 20. Total Days. Show the total days of covered inpatient care. Exclude any days for which payment may not be made because benefits have been exhausted (unless the billing form is being sent to the intermediary under the provisions of § 450).

Item 21. Date Active Care Ended. Show the date on which active treatment ended. If this is an interim billing and the patient is still receiving active treatment, check "Continuing."

Item 22. Date Guarantee of Payment or UR Notice Received. Use this section to report either of the following dates:

(a) The date of receipt of the Reply to the Notice of Admission, if this notice shows that the patient is eligible for fewer days of inpatient services than already provided in the current hospitalization.

(b) The date of receipt by the hospital of the finding by the physician members of the Utilization Review Committee (or the group responsible for review of utilization) that a further hospital stay was not medically necessary.

Cross out the item which does not apply. The guarantee of payment provision does not apply unless the hospital establishes that it acted in good faith in assuming the individual was entitled to have payment made for hospital services, and acted reasonably in assuming that the patient's inpatient days had not been and were not about to be exhausted. See § 286 for an explanation of the guarantee of payment provision.

Where the guarantee of payment provision applies, the hospital should attach a statement indicating why it believes that the requirements of the provisions are met.

Item 23. Date Benefits Exhausted. If the patient is still hospitalized and no further days are available, show the last day for which the benefits were payable. No



EXPLANATION OF ACCOMMODATION FURNISHED

1. PATIENT'S LAST NAME

2. HEALTH INSURANCE CLAIM NUMBER

3. HOSPITAL OR EXTENDED CARE FACILITY NAME AND ADDRESS

4. PROVIDER NO.

5. MEDICAL RECORD NO.

TYPE OF ACCOMMODATION FURNISHED

6A. MOST PREVALENT SEMI-PRIVATE RATE

\$

B. 1-BED

C. 5-OR-MORE-BED

FROM (Date)	TO (Date)	RATE	FROM (Date)	TO (Date)	RATE

REASON FOR ASSIGNMENT TO ACCOMMODATION MENTIONED

7A. PATIENT'S REQUEST - The 5-or-more-bed accommodation shown above was furnished because I requested it.

PATIENT'S SIGNATURE

DATE

B. MEDICAL NECESSITY (Describe)

C. OTHER REASON (Specify)

D. SIGNATURE OF HOSPITAL REPRESENTATIVE

DATE

FOR INTERMEDIARY USE

9. Where intermediary determines that assignment to 5-or-more-bed room was not at patient's request, or was not consistent with the purposes of the Act, give difference between total of charges for accommodation at the most prevalent 2-3-4-bed-room rate and charges for a 5-or-more-bed room for all covered days included on bill for services attached.

\$

10. INTERMEDIARY APPROVAL

DATE

entry should be made in this space when the Reply to the Notice of Admission showed that no days are available.

Items 24 and 25. Discharge Information. In item 24 if the patient is still hospitalized when the billing is submitted, check "Still Patient." If the patient is released from the hospital, check "Discharged." Check "Died" if the patient died in the hospital. Show the date of discharge or death in item 25.

Item 26. Computation of Interim Payment. Payments to the hospital under the hospital insurance plan are based on the reasonable cost of services provided.

The precise reasonable cost of services cannot be determined until the end of the year when final cost figures are known. An interim settlement is made on the basis of each bill, however. This interim settlement will be made by a method established by the intermediary on the basis of the hospital's previous cost experience. The hospital may wish to make a computation on its own copy of the form. If the hospital wishes to make a computation for its own records it can estimate the cost of all covered services and subtract the applicable deductibles and coinsurance to arrive at the reimbursement amount.

Item 27. Verified Prior Stay Dates and Provider Number. DO NOT USE.

Item 28. Hospital Certification and Signature Line. A hospital representative should make sure that the required physician's certification and recertifications are in the hospital records. The representative should then sign and date the form before it is submitted to the intermediary.

Item 29. Approved By and Date. DO NOT USE.

410.2 Disposition of Copies of Completed Forms SSA-1485.—Retain the copy designated "Hospital Copy" and submit the remaining copies to your intermediary (or SSA in direct dealing situations). The remaining copies to be submitted to the intermediary or SSA constitute the following:

a. The original copy which is maintained in the intermediary's (or SSA's) files.

b. The copy designated "Social Security Administration Copy."

c. The copy designated "Carrier Copy." The intermediary will send this copy to the intermediary for physicians' services.

412. EXPLANATION OF ACCOMMODATION FURNISHED (FORM SSA-1484)

Form SSA-1484, Explanation of Accommodation Furnished, is used by the hospital to explain an accommodation furnished other than a two- three- or four-bed room.

The cost of a one-bed accommodation is covered by hospital insurance if it is medically necessary. In

this case, the medical necessity should be explained on the form SSA-1484. However, where the patient requested a one-bed accommodation for reasons of personal preference, he is expected to pay the difference between the semiprivate rate and the one-bed rate. In this situation, the hospital shows the one-bed rate in the total charges column of 17A and the difference between the one-bed charges and the most prevalent semiprivate charges in the noncovered charges column of item 17A of the inpatient billing form. It is not necessary, in this situation, to complete the form SSA-1484 or to attach any special explanation to the hospital admission and billing form.

Where the assignment of a five-bed accommodation was not at the patient's request and not for a reason which the intermediary approves, the hospital may be subject to the special deduction in its cost settlement described in § 210.1C. The reason for making the five-bed accommodation should be given on the form SSA-1484. If the patient requested this accommodation, he should sign the form SSA-1484.

A hospital need not complete this form on individual claims where the intermediary has given its general approval for reimbursement for one-bed accommodations which are not medically necessary and unrequested assignments to a five or more bed room. This would be given, for instance, when all rooms were private.

412.1 Completing Items on the Form SSA-1484

Item 1. Patient Identification. This should be the same name shown on the inpatient billing form to which the SSA-1484 will be attached.

Item 2. Health Insurance Claim Number. This should be the same number as is shown on the billing form.

Item 3. Hospital or Extended Care Facility Name and Address. The name and address of the hospital is shown here.

Item 4. Provider Number. This is the hospital's provider number as shown on its notice of participation.

Item 5. Medical Record Number. This is the patient's medical record number, if one is assigned by the hospital.

Item 6. Type of Accommodation Furnished. This section calls for the period for which the accommodation was furnished and the applicable daily rate for the accommodation furnished. Item A, the most prevalent semiprivate rate, should be completed in all cases. This is the semiprivate rate most frequently used in the hospital. Items B and C dates should agree with the dates in the Statement Covers Period, item 18, on the inpatient admission and billing.

OUTPATIENT HOSPITAL BILLING
HOSPITAL AND MEDICAL INSURANCE BENEFITS - SOCIAL SECURITY ACTForm Approved.
Budget Bureau No. 72-R738

1. PATIENT'S LAST NAME			FIRST NAME		MI	2. HEALTH INSURANCE CLAIM NUMBER					
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)						4. DATE OF BIRTH		5. SEX <input type="checkbox"/> M <input type="checkbox"/> F			
6. HOSPITAL NAME AND ADDRESS				7. PROVIDER NO.		9. NAME AND ADDRESS OF PHYSICIAN REQUESTING OUTPATIENT SERVICES					
				8. MEDICAL RECORD NO.							
10. PAYMENT SOURCE FOR CHARGES TO PATIENT <input type="checkbox"/> SELF OR FAMILY <input type="checkbox"/> BLUE CROSS BLUE SHIELD <input type="checkbox"/> PUBLIC AGENCY (Give name) <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> EMPLOYER OR UNION <input type="checkbox"/> OTHER (Explain)								11. DATE OF FIRST VISIT			
12. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.											
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)								DATE			
13. DIAGNOSES (Primary illness and secondary or complicating illnesses)						EMPLOYMENT RELATED <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, give name and address of employer.		Leave Blank			
14. DATE OF EACH SERVICE		FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN			TOTAL CHARGES	HOSPITAL PLAN CHARGES	MEDICAL PLAN CHARGES			NON-COVERED CHARGES	
15A. Total Occasions of Service		HOSPITAL PLAN		MEDICAL PLAN		15B. Total Charges		\$	\$	\$	\$
16. Professional component included in 15B total charges										FOR INTERMEDIARY USE VERIFIED PATIENT LIABILITY	
17. 15B total charges less professional component shown in 16											
18. PATIENT PAID A. Deductible B. Coinsurance											
FOR INTERMEDIARY USE										PAYMENT DISTRIBUTION	
19. PART A		A. REIMB. RATE	B. A TIMES 15	C. DEDUCTIBLE	D. B LESS C	E. 80% OF D	HOSPITAL	PATIENT			
20. PART B											
21. PART A DEDUCTIBLE AS PART B EXPENSE		A. DEDUCTIBLE AMOUNT	B. REMAINING PART B DEDUCTIBLE	C. A LESS B	D. 80% OF C						
						TOTALS		\$	\$		
I certify that the required physician's certification on file.											
22. SIGNATURE OF HOSPITAL REPRESENTATIVE					DATE FORWARDED		23. APPROVED BY		DATE		

Item 7. Reason for Assignment to Accommodation Mentioned

A. Patient's Request

Where a five or more bed accommodation was furnished at a patient's request, the patient should be requested to sign the SSA-1484 in this item.

B. Medical Necessity

Describe the reason for assignment to a one-bed room from the physician's order shown in the hospital records.

C. Other Reasons

Where the hospital believes that an assignment to a one-bed or five or more bed accommodation is justifiable for some other reason, it should describe the reason in this block.

D. Signature of Hospital Representative

The responsible hospital representative should sign and date the form in this item.

Items 9 and 10. DO NOT USE.

420. OUTPATIENT HOSPITAL BILLING (FORM SSA-1483)

This form should be used by the hospital to claim reimbursement for all outpatient services. Outpatient diagnostic services covered by the hospital insurance plan are described in § 231, and outpatient treatment services covered under the medical insurance plan are described in §§ 240 ff. (See also § 230.) The SSA-1483 may be used for one or both types of service.

a. When To Submit This Form. If the items or services are reimbursable only under the medical plan or if diagnostic tests under the hospital plan are in conjunction with outpatient hospital services under the medical plan, send the completed form to the intermediary (or to SSA if you deal directly) as soon as possible.

If there are charges only under the hospital plan, submit it after 20 days or when the study ends, whichever is earlier.

Sometimes after a hospital believes a study had ended, a patient may return for new diagnostic tests, after the bill has been submitted, but within the 20-day period specified in § 232. If this should happen, the \$20 deductible does not apply to any new services within the 20-day period.

It may also happen that a diagnostic study lasts more than 20 days. Treat a diagnostic study which is still in effect at the end of 20 days as a new diagnostic study, beginning the 21st day, and prepare a new billing form for the next 20-day period.

b. Determining How Much To Charge Outpatient Before Billing Is Submitted. The deductibles and coinsurance payable under the hospital insurance plan for outpatient services are described in §§ 232.1 and 232.2. The deductibles and coinsurance for the medical insurance plan are described in §§ 246 and 247.

The \$20 deductible under the hospital plan for outpatient diagnostic services is an incurred expense under the medical insurance plan.

The hospital may be able to determine from its records or from the patient that the medical plan deductible has already been met. (The patient is sent a notice when the medical plan deductible is met.)

When the intermediary receives an outpatient billing, it will query the Social Security Administration central record for the Part B deductible status information required for computing the payments.

1. Patient Has Both Hospital and Medical Plan Entitlement.

(a) *Medical Plan Deductible Is Not Met or Its Status Is Unknown*—You may prefer to wait to bill the patient until the intermediary has verified the deductible status. If you do bill the patient, any overcollection of the deductible and coinsurance will be refunded direct to the patient from the intermediary.

The hospital can use these guidelines in billing:

(1) *Patient has diagnostic services only.* Charge up to \$20 plus 20 percent of any balance in excess of \$20.

(2) *Patient has medical plan services only.* Charge not more than the \$50 deductible and 20 percent of any balance.

(3) *Patient has a mixture of diagnostic and therapeutic services.*—For diagnostic services, charge up to \$20 plus 20 percent of any balance. For therapeutic services, charge the amount necessary to meet the \$50 medical plan deductible (after considering the amount of the diagnostic deductible charge as an incurred expense) and 20 percent of any balance.

(b) *Medical Plan Deductible Is Met*—Charge 20 percent of the total, whether the services are diagnostic or therapeutic.

2. Patient Has Hospital Plan Entitlement Only.—Only diagnostic services are covered. Charge up to \$20 plus 20 percent of any remainder, and the full amount of any charges for therapeutic services.

3. Patient Has Medical Plan Entitlement Only.—Both diagnostic and therapeutic services are covered under the medical plan.

Where the deductible is known to be met, charge 20 percent of the total.

Where the deductible is not met or its status is unknown, charge no more than \$50 and 20 percent of any balance. Here the hospital may prefer to wait to bill the patient until the intermediary has verified the deductible status.

c. Billing Examples.

Example 1: Hospital knows patient has met Part B deductible. Outpatient hospital diagnostic services reasonable charge is \$40. The hospital bills the patient \$8 (20 percent of the total). The intermediary reimburses the hospital 80 percent of the \$20 Part A deductible (\$16), plus 80 percent of the estimated reasonable cost of the services above the \$20 Part A deductible.

Example 2: Patient has met Part B deductible, but hospital has not been able to ascertain that fact. Outpatient hospital diagnostic services reasonable charge is \$40. Hospital bills patient \$24 (the \$20 Part A deductible, plus 20 percent of the remainder). Intermediary determines by querying SSA central records that Part B deductible had been met. The intermediary reimburses the hospital for 80 percent of the reasonable cost above the \$20 deductible and reimburses the patient \$16 (80 percent of the \$20 Part A deductible).

Example 3: It is uncertain whether the patient has met Part B deductible. Outpatient hospital diagnostic services reasonable charge is \$40. Hospital chooses not to bill the patient until the intermediary has verified the deductible. The intermediary queries the SSA central record and determines that the patient had not met any part of the Part B deductible. It reimburses the hospital 80 percent of the estimated reasonable cost of the services above the \$20 Part A deductible, and informs the hospital it should bill the patient for \$24, i.e., the Part A deductible, plus \$4 coinsurance.

Example 4: Patient has \$80 in diagnostic services and \$40 in therapeutic services. The hospital believes the medical plan deductible is not met and decides to bill the patient at the same time the billing form is sent to the intermediary.

The hospital bills the patient:

\$20.00	for the diagnostic deductible
12.00	hospital plan coinsurance
30.00	medical plan deductible (considering \$20 diagnostic deductible as an incurred Part B expense)
2.00	coinsurance on the \$10 remaining medical plan charges
<hr/>	
\$64.00	Total

420.1 Completing Items on Form SSA-1483

Item 1. Patient Identification. Enter the patient's last name, first name, and middle initial from his health insurance card.

Item 2. Health Insurance Claim Number. Enter the patient's claim number as shown on his health insurance card in the "Claim Number" block.

Item 3. Patient's Address. Show the patient's mailing address from your records. Where the patient's authorized representative is signing the form on behalf of the patient, show the authorized representative's address.

Items 4 and 5. Date of Birth and Sex. Show the patient's date of birth and sex in the appropriate blocks. Use six-digit numbers for the date of birth; e.g., 01/02/95 for January 2, 1895. Show the correct sex if it differs from the HI card. Suggest to the patient that he contact the SSA district office to correct the entry.

Items 6, 7 and 8. Hospital Identification. Enter the name and address of the hospital and the hospital's provider number assigned by the Social Security Administration as shown on the hospital's Notice of Participation. These items can be preprinted on all copies of this form, if desired. Enter the patient's medical record number if one is assigned by the hospital and is required for association and reference purposes.

Item 9. Name and Address of Physician Requesting Outpatient Services. Show the name and address of the physician who requested outpatient services.

Item 10. Payment Source. Identify who will pay for any services to the patient that cannot be paid by the health insurance program. If a public agency will pay any part of the patient's charges, please show the name and address of the agency. Also show the patient's case number if it is available.

Item 11. Date of First Visit. This is the beginning date of an outpatient diagnostic study under hospital insurance represented by this bill. Do not show another date, such as the date of the first posting to the hospital record.

Item 12. Patient's Certification and Payment Request. Have the patient or his authorized representative read and sign the statement before the bill is submitted for payment. Where the patient's signature differs significantly from the name shown in item 1, add a brief explanation.

If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf (e.g., John J. Jones by Jack A. Smith). Briefly explain on the form the reason why the patient did not sign it himself and the relationship of the signer to the patient. If the patient is able to execute the application but is illiterate, have him make an "X" and have the mark witnessed by someone who knows him. In emergency situations, a hospital representative may sign on behalf of the patient.

Item 13. Diagnoses. List here, from the patient's hospital record, the diagnoses of the conditions for which outpatient services were given. If diagnosis is not known, enter "Not Known." Where there are multiple diagnoses in the record, list the primary diagnosis first, and enter the word "primary" in parentheses after it.

Check the appropriate block to show whether the condition was employment related. Show the name and address of the employer, if known. Where the hospital knows that a workmen's compensation claim has been made, it should insert or attach a statement identifying the carrier, if any, handling the workmen's compensation claim, and giving any details about the claim which are available to it.

Item 14. Statement of Services. For each date given, list the name of all medical procedures—laboratory tests, radium therapy, etc.—performed during the

period covered by this billing. List also the name of any operation or endoscopic procedure performed during the billing period. Describe any supplies or equipment furnished.

Medical and surgical procedures should be specified in detail using acceptable terminology such as that indicated by the *Current Medical Terminology*, *Current Procedural Terminology*, *Standard Nomenclature of Diseases and Operations*, the *American Psychiatric Association's Diagnostic and Statistical Manual*, etc.

In the "Charges" columns, show the total charges for each procedure and indicate whether the charge is a medical plan charge, a hospital charge, or is a non-covered charge. See §§ 230 and 240 ff. for a description of the services covered under each plan.

Where the hospital normally includes a charge for physicians' services in its total charge for a service, the total charges will be billed as usual, and the physician's component will **not** be broken out in noncovered charges. The intermediary will make a deduction for any physicians' charges in arriving at the cost reimbursement. (The physicians' services will be billed for either on the Form SSA-1490, Request for Payment, or on the Form SSA-1554, and will be reimbursed on a reasonable charge basis.)

When a posting date for a hospital plan charge occurs more than 20 days after the date shown in item 11, the intermediary will not assume that the service is within the same 20-day study period unless the hospital also shows the exact date of that service in the *Description of Services* section.

Item 15. Summary of Charges.

A. If the hospital is reimbursed by the intermediary on a cost-per-occasion-of-service basis or cost-per-visit basis, enter the total number of occasions of service or visits represented by this bill.

B. Enter the total charges pertaining to each column in item 14.

Item 16. If physician charges are included in the hospital's charges, they must be excluded in determining the deductible and coinsurance due from the patient. Enter the amounts to be excluded under each plan.

Item 17. Subtract the professional component (physicians' charges) from the total hospital and/or medical plan charges.

Item 18. Patient Paid. Enter the amounts, if any, paid by the patient or on his behalf for the deductible and/or coinsurance under each plan. Exclude any amount paid by the patient for physicians' services.

Do not use the section to the right entitled "Verified Patient Liability." The intermediary will use this space to enter the total allowable charges which are actually payable by the patient. The intermediary will advise you of the total due from the patient for the deductible and coinsurance.

The remainder of this form is for use of the intermediary; however, if the hospital wishes, it may estimate the interim reimbursement amount by either using the hospital copy of the form or a separate piece of paper.

Item 19 is to show the payment computation for outpatient diagnostic studies under the hospital plan.

Item 20 is to show the payment computation for medical and other health services under the medical plan.

Item 21 is to show the treatment of the outpatient diagnostic deductible as an incurred expense under the medical plan.

The intermediary distributes the payment between the patient and hospital, if necessary, taking into account the payments which the hospital received from the patient before the billing form was submitted to the intermediary.

Item 22. Signature of Hospital Representative.

Before the billing is forwarded to the intermediary, a hospital representative should assure himself that the necessary physician's certification is on file. He should sign his name and show the date.

Item 23. To be completed by the intermediary.

420.2 Disposition of Copies of Completed Forms SSA-1483.

—Retain the copy designated "Hospital Copy" and submit the remaining copies to your intermediary (or SSA in direct dealing situations). The remaining copies to be submitted to the intermediary or SSA constitute the following:

a. The original copy which is maintained in the intermediary's (or SSA's) files.

b. Two copies designated "Social Security Administration Copy."

c. The copy designated "Carrier Copy." (This copy serves the same purpose as described under Form SSA-1453.)

430. PROVIDER BILLING FOR PATIENT SERVICES BY PHYSICIAN (FORM SSA-1554)

A. This form is used to bill for physicians' services in a hospital where:

1. The beneficiary assigns payment to the physician,
2. The physician agrees that the reasonable charge, as determined by the intermediary, will be the full charge for services rendered and,

3. The physician has authorized the hospital to accept the assignment and collect the payment on his behalf.

The form should be attached to the inpatient or outpatient bill for the stay or services to which the physicians' charges apply. It should be forwarded with the

1. PATIENT'S LAST NAME	FIRST NAME	MI	2. HEALTH INSURANCE CLAIM NUMBER
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)			
4. DATE OF BIRTH			5. SEX <input type="checkbox"/> M <input type="checkbox"/> F
NAME AND ADDRESS OF PROVIDER			7. PROVIDER NO(S)
			8. MEDICAL RECORD NO.

9. ASSIGNMENT: I assign payment for unpaid charges of the physician(s) listed on this form.

AUTHORIZATION: I authorize release of any information required to act on this claim and permit a photographic reproduction of this authorization to be used in place of the original.

The above information is correct. I request payment on my behalf for the medical insurance benefit, if any, payable for the reasonable charges for services described. I understand I am responsible for any medical insurance deductible and the coinsurance based on reasonable charges.

SIGNATURE OF PATIENT (Or his representative)

SIGNATURE OF PATIENT (Or his representative)										DATE SIGNED	
11. DIAGNOSES AND CONCURRENT CONDITIONS											
10A.	B.	C.	D.	E.	F.	G.	H.	LEAVE BLANK			
DATE OF EACH SERVICE	NAME OF PHYSICIAN	PLACE OF SERVICE H.O.H.E.C.F.H.	FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES	DEPARTMENT	TOTAL CHARGE WHEN APPLICABLE	PERCENTAGE OF TOTAL CHARGE	CHARGE FOR PHYSICIANS SERVICES				
								TOTALS \$			
								Deductible and coinsurance paid			
								Any unpaid balance			

13. PROVIDER CERTIFICATION: The physicians named in item 10B have authorized the provider to accept assignment and receive payments in their behalf (and such authorizations are on file and still in effect.)

SIGNATURE OF PROVIDER REPRESENTATIVE

SSA-1453, SSA-1483, or SSA-1485 to your regular intermediary for provider services. Your intermediary will forward it to the carrier for physicians' services with his copy of the regular billing form.

Do not use this form if the patient has paid all the charges. Instead, furnish the patient with a fully itemized and receipted bill, identifying each physician, his charges, dates of service, and procedures. Inform the patient that he may claim reimbursement by attaching the bill to a Request for Payment (Form SSA-1490.) **Do not use this form to report the services of a physician who wishes the medical insurance payment to be made directly to him.** Inform that physician that he and the patient may complete a Request for Payment for that purpose.

B. The following is a sample of an authorization for use by providers in connection with provider billing for physicians' services. **A one-time execution of this authorization is all that is necessary by each physician.** The authorization should be retained in the provider's files.

"I hereby authorize the (*name of institution*) or any of its duly authorized administrators to accept on my behalf any assignment made by any individual who receives medical treatment from me at the (*name of institution*) of the amount payable to such individual under Part B of Title XVIII of the Social Security Act and to receive on my behalf any payments which may be made pursuant to such assignment. It is understood and agreed that the reasonable charge which will serve as the basis for payment in accordance with the terms of such assignment shall be the full charge for the services."

An additional statement should also include the individual arrangements agreed upon by the provider and the physician governing the conditions of withdrawing the authorization.

430.1 Completing Items on Form SSA-1554

Item 1. Patient Identification. The patient's name should be the same as that shown on his health insurance card with the last name first. It is important to use the same name on the form as on the card even though the beneficiary may have changed his name.

Item 2. Health Insurance Claim Number. Enter the health insurance claim number shown on the patient's card. If the patient does not have his card, the information may be obtained from a Notice of Hospital Insurance Utilization or Explanation of Benefits form. These forms are furnished each patient soon after payment has been made for hospital or medical services.

Item 3. Patient's Address. Show the address of the person who is assigning benefits, whether this is the patient or someone acting on his behalf.

Items 4 and 5. Date of Birth and Sex. Complete the "Date of Birth" and "Sex" blocks in all cases. Use six-digit numbers for the date of birth; e.g., 01/02/95, for January 2, 1895.

Items 6 and 7. Provider Identification. Enter the name and address of the hospital and the provider number as shown on the institution's Notice of Participation. These items may be preprinted.

Item 8. Medical Record Number. Show the patient's medical record number if one is assigned by the provider and is required for association and reference purposes.

Item 10. Authorization and Signature. If a patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf; e.g., John J. Jones by Jack A. Smith. Briefly explain the reason why the patient did not sign himself and the relationship of the signer to the patient. If the patient is able to execute the application but is illiterate, have him make an "X" and have the mark witnessed by someone who knows him. The witness to the mark should sign his own name and show his address on the signature line.

If the patient has changed his or her name, have the patient sign the new name. Briefly explain why the name is different from that shown in item 1.

Have the person signing show the date signed.

Item 11A. Date of Service. Show the dates for each time the physician furnished services. Where the dates are not normally available from the hospital record, the billing method should be discussed with the intermediary.

Item 11B. Name of Physician. Show the name of the physician for whom the hospital is billing for services. Upon arrangement with the intermediary, billing may be in the name of the hospital department head.

Item 11C. Place of Service. Enter codes "IH" for hospital inpatient, "OH" for hospital outpatient.

Item 11D. Surgical or Medical Procedures. For each date shown, give the surgical or medical procedures performed during this billing period as entered in the patient's medical record. The surgical or medical procedure should be clearly identified by the use of standard nomenclature.

Item 11E. Department. Enter the name of the department associated with the physician's services; e.g., X-ray, emergency room, or laboratory.

Items 11F and 11G. Total Charge and Percentage of Total Charge. If the hospital accounts for physicians' charges as a percentage of the departmental charge, show in item 11F the total charges attributable to the department shown in item 11E and the percentage of the total departmental charge in item 11G.

Details as to distinguishing the physician charge from costs which are reimbursable to the hospital under the hospital insurance plan are contained in the hospital reimbursement principles.

Item 11H. Charge for Physicians' Services. Enter the money amount attributable to physicians' services. Total all physicians' charges and enter the amount in the "Totals" block. Show any part of the \$50 deductible and coinsurance paid by the patient and subtract the amount paid from the total charges.

Item 12. Diagnosis and Concurrent Conditions. Show the most significant of the conditions first in entering diagnoses. Use recognized nomenclature such as that contained in *Current Medical Terminology*, *Standard Nomenclature of Diseases and Operations*, and the American Psychiatric Associations' *Diagnostic and Statistical Manual*, etc. Show any concurrent conditions associated with the primary diagnosis.

Item 13. Employment Related. Indicate whether the condition is employment related. If the condition is or may be employment related, give the name and address of the employer, if known. Payment may be made subject to reimbursement if a workmen's compensation claim is pending and no settlement is foreseeable.

Item 14. Provider Certification, Signature, and Date. The signature of the hospital representative serves as a request for payment on behalf of physicians. The signature is also a certification that proper authorizations by the physicians shown in 11B are on file and are still in effect.

430.2 Disposition of Form SSA-1554.—Since this form has only a single copy, the hospital may wish to make a carbon copy when preparing the form, for its own files. The original should be attached to the inpatient or outpatient bill and forwarded to the intermediary for provider services. Where no inpatient or outpatient bill is being submitted, send the form direct to the intermediary for physicians' services.

450. PROCEDURE FOR SUBMITTING INPATIENT BILLING AFTER EXHAUSTION OF BENEFITS

The benefit days available to a beneficiary depend on the status of his prior utilization of services during this "spell of illness" as described in § 215.

The days that the beneficiary spends in the hospital after his 90-benefit days have been exhausted must be reported by the hospital so that the intermediary and the Social Security Administration will know when a spell of illness ends.

The information submitted on a billing form after benefits have been exhausted is limited to identifying information, critical dates, and essential statistical data.

Items 1, 2, 4, 7, 10, 12, 15, 16, 17 (line 0), 22, and 23 are the only items required on the Form SSA-1453, Inpatient Hospital Admission and Billing. Items 1, 2, 4, 7, 10, 13, 16, 17, 18 (line 0), 24, and 25 should be completed on Form SSA-1485, Inpatient Psychiatric or Tuberculosis Hospital Admission and Billing.

The hospital detaches the two admission copies and sends the top three copies of the form to the intermediary in the usual manner. Only one billing form need be completed for the period after benefits are exhausted, regardless of the length of time involved. This form may be completed after discharge or death.

460. PROCEDURE FOR SUBMITTING CORRECTED BILLS

The hospital may discover that a bill already submitted is incorrect.

To correct a previously submitted bill, the hospital should reproduce three copies of the previously submitted bills and make the necessary corrections on two of them. The corrected copies should be marked "Debit-Adjust" in the upper right margin and the third copy should be marked "Credit-Cancel" in the upper right margin.

All copies should be submitted to the intermediary.

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HEALTH INSURANCE FOR THE AGED

CHRISTIAN SCIENCE SANATORIUMS

MANUAL SUPPLEMENT

(This supplement is intended for use by Christian Science sanatoriums in conjunction with the Hospital Manual. The material has been organized on the same basic pattern as the Hospital Manual, so that it can be filed as a whole at the end of the Hospital Manual or inter-filed by chapter.)

U.S. Dept. of Health, Education & Welfare

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Social Security Administration
June 1966

CHRISTIAN SCIENCE SANATORIUMS

Manual Supplement

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CHRISTIAN SCIENCE SANATORIUMS

Manual Supplement

COVERAGE OF SERVICES

CS-200. COVERAGE OF CHRISTIAN SCIENCE SANATORIUM SERVICES--GENERAL

Under the hospital insurance program, two separate types of benefits are payable for care furnished by a Christian Science Sanatorium: inpatient Christian Science sanatorium services and sanatorium extended care services. However, payment may not be made under either the hospital or medical insurance program for services furnished by a Christian Science practitioner, a Christian Science nursing home, a Christian Science rest home, or a Christian Science visiting nurse service.

Sanatorium Services are covered items and services furnished by a Christian Science sanatorium, regardless of whether the items and services are furnished by the sanatorium in its capacity as a hospital or in its capacity as an extended care facility.

Care furnished by a sanatorium in either its capacity as a hospital or extended care facility is covered only if the patient is receiving skilled Christian Science nursing care, that is, intensive care or a lesser degree of skilled nursing care. Custodial care and rest and study are not covered.

CS-202. INPATIENT CHRISTIAN SCIENCE SANATORIUM SERVICES are sanatorium services furnished by a Christian Science sanatorium in its capacity as a hospital.

Payment for inpatient Christian Science sanatorium services furnished an individual may be made for up to 90 days in any one spell of illness. For each spell of illness, there is a deductible amount equal to the inpatient hospital deductible (\$40 initially), and a coinsurance amount equal to one-fourth (\$10 initially) of the inpatient hospital deductible for each day after the 60th day on which such services are furnished during the spell of illness. Benefits will be payable for services furnished on or after July 1, 1966.

In any given spell of illness, in addition to payment for inpatient Christian Science Sanatorium services, payment can also be made on behalf of an individual for inpatient hospital services in a regular medical hospital. However, the total number of days during a spell of illness for which payment may be made for both inpatient hospital services and inpatient Christian Science sanatorium services cannot exceed 90 days. Where an individual is furnished both covered inpatient hospital services and covered inpatient Christian Science sanatorium services during the same spell of illness, the deductible amount applies only once.

The guarantee of payment provision (see § 286 of the Hospital Manual) applies to inpatient Christian Science sanatorium services, but does not apply to sanatorium extended care services.

CS-204. SANATORIUM EXTENDED CARE SERVICES are sanatorium services furnished by a Christian Science sanatorium in its capacity as an extended care facility.

Payment for sanatorium extended care services may be made only if the individual elects to treat sanatorium services as sanatorium extended care services. If the individual makes this election (see § CS-204.1) the sanatorium services will be considered to be furnished by the sanatorium in its capacity as an extended care facility. An election to treat sanatorium services as sanatorium extended care services does not preclude payment thereafter during the same spell of illness for inpatient Christian Science sanatorium services.

Payment for sanatorium extended care services may be made for up to 30 days in each spell of illness, instead of the 100 days applicable to extended care services generally. For each day of covered services, there is a coinsurance amount equal to one-eighth (\$5 initially) of the inpatient hospital deductible. Benefits will be payable for services furnished on or after January 1, 1967.

Payment may not be made on behalf of an individual for sanatorium extended care services furnished him after he has been furnished post-hospital extended care services during the same spell of illness as an inpatient of a qualified extended care facility which is not a Christian Science sanatorium. Similarly, payment may not be made for posthospital extended care services furnished to an inpatient of an extended care facility which is not a Christian Science sanatorium after he has been furnished, during the same spell of illness, covered sanatorium extended care services.

CS-204.1 Election to Treat Sanatorium Services as Sanatorium Extended Care Services

Sanatorium services are considered to be furnished by a sanatorium in its capacity as a hospital unless the individual elects to have them treated as sanatorium extended care services. The presence or absence of such an election, rather than the degree of skilled Christian Science nursing care rendered the patient, determines whether the services are covered as inpatient Christian Science sanatorium services or sanatorium extended care services. An individual may elect to treat any degree of skilled Christian Science nursing care (e.g., intensive Christian Science nursing care, or skilled, continuing Christian Science nursing care) as sanatorium extended care services.

A patient may not elect to treat custodial care or rest and study as sanatorium extended care services, since such care is not covered by the program. Physical transfer of the patient to an extended care part, unit, or wing of the sanatorium is not required; nor is a prior hospital stay or a stay in a Christian Science sanatorium in its capacity as a hospital required.

The individual's election to have sanatorium services treated as "sanatorium extended care services" must be made in writing and be signed by the individual or a proper party on his behalf. (See § CS-300.1 for method of making election.) The election is effective beginning with the date indicated by the individual in making the election; it remains in effect until either (1) the individual is no longer an inpatient of the sanatorium or is no longer receiving covered sanatorium services although still an inpatient, or (2) his election is withdrawn. (A request for payment for sanatorium services signed by the individual or a proper party on his behalf which is not accompanied by an election has the effect of withdrawing a previous election to have sanatorium services treated as sanatorium extended care services.)

CS-205. INPATIENT SERVICES COUNTING TOWARD MAXIMUMS

A day of inpatient Christian Science sanatorium services or sanatorium extended care services counts toward the limitations on duration of coverage if (1) payment for the services is made, or (2) payment for the services would be made if a request for payment were properly filed and if the utilization review committee verified that sanatorium services were necessary.

CS-206. COVERED ITEMS AND SERVICES

Covered sanatorium services furnished by a Christian Science sanatorium in its capacity as either a hospital or extended care facility include items and services ordinarily furnished by a Christian Science sanatorium to its inpatients, but only to the extent that such items and services are comparable to, or are the Christian Science equivalent of, items and services which would constitute inpatient hospital services if furnished by a hospital.

The primary items and services covered as sanatorium services include nursing and related services, bed and board, and certain supplies, equipment and appliances used as part of the Christian Science method of healing.

Coverage of bed and board is on the basis of the standard private sanatorium accommodation. Where more expensive accommodations than the standard private accommodation are furnished, payment will be made on the basis of the reasonable cost of the standard private accommodation; the patient may be charged the amount by which the customary charges for the standard and the deluxe accommodations differ.

Items and services comparable to those which are not covered as in-patient hospital services are not covered as sanatorium services. Thus, if the services of a Christian Science nurse are those of a private-duty nurse or attendant, they will not be covered. Similarly, the services of a Christian Science practitioner, who is the Christian Science counterpart of the physician, will not be covered.

The general exclusions from coverage listed in § 260 of the Hospital Manual will also apply, where appropriate, to care furnished by Christian Science sanatoriums. For example, personal comfort items if furnished by a sanatorium will be excluded from coverage. Also, care furnished by a sanatorium which amounts to custodial care is not covered. The exclusion with respect to payment under a workmen's compensation plan applies to sanatorium services where the applicable workmen's compensation plan covers Christian Science care. Also excluded from coverage are items and services furnished by a sanatorium to a "rest and study" guest.

CS-208. VERIFICATION AND REVERIFICATION

Verification and reverification are made by the sanatorium's utilization review committee as to the patient's need for covered sanatorium services. Reviews by the committee of each beneficiary admission and each beneficiary stay of extended duration (no less frequently than as of the 14th day of the individual's sanatorium stay and each 30th day thereafter) pursuant to the sanatorium's utilization review plan constitute the necessary verification and reverifications as long as the committee's decision that the sanatorium services are necessary is recorded in its records or the patient's records. Delayed verifications or reverifications will be acceptable where, for example, there has been an oversight or lapse; however, in such cases, the records should contain an explanation for the delay. Sanatoriums are not required to send statements for the verification and reverification to the intermediary; instead, the sanatorium must itself certify, on the admission and billing form, that the required verification and reverifications have been made and are on file.

CS-208.1 Individual Admitted before Entitlement

If an individual is admitted to a sanatorium before he is entitled to benefits (for example, before July 1, 1966, or before he reaches age 65), the following rules are applicable when he does become entitled:

No verification (review by the utilization review committee of the necessity for inpatient admission) is required. reverifications (review of patient's need for continued covered sanatorium services) are required as of the time they would be required if the patient had been admitted on the day he became entitled. For example, if a patient becomes entitled to benefits on July 1, 1966, but was admitted prior to that date, the first reverification is required no later than July 14; thereafter, subsequent reverifications are required at intervals not to exceed 30 days. Similarly, if a patient becomes entitled on September 1, but was admitted prior to that date, the first reverification is required no later than September 14.

CS-215. UTILIZATION REVIEW--LIMITATIONS ON PAYMENT

A. Deficient Utilization Review--If it is determined that a participating sanatorium is not making timely utilization reviews of long-stay cases, the Social Security Administration could, as with hospitals and extended care facilities, terminate its agreement with the sanatorium.

However, in lieu of taking such action, the Administration may limit payment to the sanatorium, in the case of each beneficiary admitted to the institution after the effective date of this determination, to a maximum of 20 days of continuous sanatorium services (including both days treated as inpatient Christian Science sanatorium services and days treated as sanatorium extended care services). The Administration will determine the effective date of this limitation. Notice of its decision must be given to the public and the sanatorium.

B. Adverse Finding by Utilization Review Committee--If the sanatorium utilization review committee determines that further covered sanatorium services for a beneficiary are not necessary, payment may not be made for covered sanatorium services furnished a beneficiary after the third day following the date the sanatorium received notice from the utilization review committee that further covered sanatorium services are not necessary. (Such notice is required to be given promptly in writing to the practitioner on the case, the patient or his representative, and the sanatorium.)

INPATIENT ADMISSION AND BILLING - CHRISTIAN SCIENCE SANATORIUM
HOSPITAL INSURANCE BENEFITS - SOCIAL SECURITY ACT

Exhibit 3-1

1. PATIENT'S LAST NAME		FIRST NAME	IMI	2. HEALTH INSURANCE CLAIM NUMBER	
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)				4. DATE OF BIRTH	5. SEX <input type="checkbox"/> M <input type="checkbox"/> F
6. SANATORIUM NAME AND ADDRESS		7. PROVIDER NO.		9. NAME AND ADDRESS OF ATTENDING CHRISTIAN SCIENCE PRACTITIONER	
		8. SANATORIUM RECORD NO.			
10. NAME AND ADDRESS OF ANY INSTITUTION FROM WHICH DISCHARGED AS INPATIENT DURING LAST 60 DAYS (If this institution, give dates of stay.)				11. DATE OF ADMISSION FOR INPATIENT CHRISTIAN SCIENCE SANATORIUM SERVICES	12. DATE OF ELECTION OF EXTENDED CARE
13. PAYMENT SOURCE FOR CHARGES TO PATIENT <input type="checkbox"/> SELF OR FAMILY <input type="checkbox"/> BLUE CROSS BLUE SHIELD <input type="checkbox"/> PUBLIC AGENCY (Give name) <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> EMPLOYER OR UNION <input type="checkbox"/> OTHER (Agency)					
14. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf. I elect extended care services beginning with the date shown in item 12.					
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)					DATE
15. IF REASON FOR ADMISSION IS WORK RELATED, GIVE NAME AND ADDRESS OF EMPLOYER					

REPORT OF ELIGIBILITY

A. Effective Date - Hospital Insurance			J. Open Item Information 1. Intermediary
B. Hospital Days Remaining	FULL	COINSURANCE	
C. Remaining Inpatient Deductible	\$		
D. ECF Days Remaining			
Remarks:			2. Provider
			3. Date Admitted
			4. Date Discharged
			INTERMEDIARY APPROVAL

CHRISTIAN SCIENCE SANATORIUMS

Manual Supplement

ADMISSION PROCEDURES

CS-300. NOTICE OF ADMISSION

The notice of admission information will be entered in items 1 through 15 of Form SSA-1486, Inpatient Admission and Billing - Christian Science Sanatorium (Exhibit 3-1). This form will be used as a notice of admission for both inpatient Christian Science sanatorium services and sanatorium extended care services.

If a patient has both types of services during the same stay, a separate form and admission notice must be initiated for each. For example: A patient is admitted for inpatient Christian Science sanatorium services. An admission form is completed and a notice of admission forwarded at that time. If the patient later elects to treat sanatorium services as extended care services during the same stay, another admission notice must be initiated. The sanatorium will use the appropriate provider number for inpatient Christian Science sanatorium services or for sanatorium extended care services, whichever is applicable. Separate billings for each type of service should be submitted.

CS-300.1. Election of Extended Care Services

The entry of the date of election of extended care service in item 12 and the patient's signature in item 14 of the SSA-1486 will serve as an election of sanatorium extended care services. If item 12 is not completed, and the individual wishes the service to be treated as sanatorium extended care services, a supplementary form may be submitted. Enter "SUPPLEMENT" in the top margin of the form and complete only items 1, 2, 12 and 14.

CS-300.2. Work-Related Conditions

In item 15 of the SSA-1486, enter the name and address of the employer if the admission is for a work-related condition. If the patient does not know the name and address, enter "YES." Obtain the information before submitting a billing.

CS-305. REPLY TO NOTICE OF ADMISSION--EXTENDED CARE SERVICES

The number of sanatorium extended care services days available for the current spell of illness will be shown in item D of the "Report of Eligibility." Where applicable "None" will be entered in this item.

INPATIENT ADMISSION AND BILLING - CHRISTIAN SCIENCE SANATORIUM
HOSPITAL INSURANCE BENEFITS - SOCIAL SECURITY ACT

Exhibit 4-1

1. PATIENT'S LAST NAME			FIRST NAME			MI			2. HEALTH INSURANCE CLAIM NUMBER										
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)									4. DATE OF BIRTH			5. SEX <input type="checkbox"/> M <input type="checkbox"/> F							
6. SANATORIUM NAME AND ADDRESS						7. PROVIDER NO.			9. NAME AND ADDRESS OF ATTENDING CHRISTIAN SCIENCE PRACTITIONER										
						8. SANATORIUM RECORD NO.													
10. NAME AND ADDRESS OF ANY INSTITUTION FROM WHICH DISCHARGED AS INPATIENT DURING LAST 60 DAYS (If this institution, give dates of stay.)									11. DATE OF ADMISSION FOR INPATIENT CHRISTIAN SCIENCE SANATORIUM SERVICES			12. DATE OF ELECTION OF EXTENDED CARE							
13. PAYMENT SOURCE FOR CHARGES TO PATIENT																			
<input type="checkbox"/> SELF OR FAMILY <input type="checkbox"/> BLUE CROSS BLUE SHIELD <input type="checkbox"/> PUBLIC AGENCY (Give name) <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> EMPLOYER OR UNION <input type="checkbox"/> OTHER (Agency)																			
14. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf. I elect extended care services beginning with the date shown in item 12.																			
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)										DATE									
15. IF REASON FOR ADMISSION IS WORK RELATED, GIVE NAME AND ADDRESS OF EMPLOYER																			
16. DATE PATIENT DISCHARGED						17. <input type="checkbox"/> DISCHARGED <input type="checkbox"/> DID NOT RECOVER <input type="checkbox"/> STILL AN INPATIENT			18. THIS STATEMENT COVERS PERIOD										
FROM INPATIENT CARE			FROM EXTENDED CARE						FROM			TO							
19. STATEMENT OF SERVICES RENDERED																			
INPATIENT CHRISTIAN SCIENCE SANATORIUM SERVICES						EXTENDED CARE													
ITEMS OF SERVICE		NO. OF DAYS	RATE	TOTAL		NON-COVERED		NO. OF DAYS	RATE	TOTAL		NON-COVERED							
A. 1 Bed																			
B. Other Accommodation (Describe)																			
C. Other Services (Specify)																			
D. TOTAL																			
20. DATE GUARANTEE OF PMT. OR UR NOTICE RECEIVED			21. DATE BENEFITS EXHAUSTED			22. COMPUTATION OF INPATIENT CARE REIMBURSEMENT				23. COMPUTATION OF EXTENDED CARE REIMBURSEMENT									
REMARKS						A. Total Covered Days				A. Total Covered Days (Maximum of 30 Days)									
						B. Deductions				B. Deductions \$5 each day of service									
						1. Inpatient Deductible													
						2. \$10 each Day 61 thru 90													
						C. Reimbursement Amount				C. Reimbursement Amount									
24. I certify that the verification, and if necessary, reverification of the patient's need for sanatorium services are on file.								25. VERIFIED PRIOR STAY DATES				PROVIDER NO.							
SIGNATURE OF SANATORIUM REPRESENTATIVE								DATE FORWARDED				APPROVED				DATE			

CHRISTIAN SCIENCE SANATORIUMS

Manual Supplement

BILLING PROCEDURES

CS.400. BILLING PROCEDURES--CHRISTIAN SCIENCE SANATORIUMS--GENERAL
The form used for billing under the hospital insurance program is:

SSA-1486--Inpatient Admission and Billing--Christian Science Sanatorium.

Form SSA-1486 will be used to bill for inpatient sanatorium services or sanatorium extended care services. Although the SSA-1486 has entries for billing both types of services, it is important to bill for only one type of service on the same form. The intermediary and SSA will process bills for inpatient sanatorium services separately from bills for sanatorium extended care services. One billing submitted for both types of services will be rejected. See sections CS-200ff. for details of covered items and services.

No payment may be made for sanatorium extended care services furnished before January 1, 1967. Billing forms submitted between July 1, 1966, and December 31, 1966, should be limited to inpatient sanatorium services.

CS.402. INPATIENT ADMISSION AND BILLING--CHRISTIAN SCIENCE SANATORIUM (FORM SSA-1486)

This form serves two purposes. It is used to report the admission of a patient who is eligible for sanatorium services so that the Social Security Administration and the sanatorium's intermediary can determine how many benefit days are available. It is also used to bill the intermediary for the payment due the sanatorium for the services rendered.

The bottom two copies of the form can be used to report the admission. (The procedures for reporting admissions are described in Sections CS-300ff.) The sanatorium fills out items 1 through 15 of all copies of the form, detaches the bottom two copies, and notifies the intermediary in accordance with its usual procedures. (If the two copies allotted for admission notification are not used for this purpose, they may be destroyed.)

Items 15 through 24 of the billing form should be completed at the time the bill is rendered. The bill may be rendered at the time the patient is discharged or after his benefits are exhausted. It also may be submitted on an interim basis.

A billing form should be submitted even where the patient is responsible for a deductible which covers the entire amount of the sanatorium charge. It should also be submitted for periods after benefits are exhausted. The submission of billing forms for periods where there is no payment due the sanatorium will enable the Social Security Administration and the intermediary to maintain a correct current record of deductibles and days available. It is not, however, necessary to complete all the items on a form if it is being submitted for a period after benefits have been exhausted. The procedure for completing and submitting forms after benefits have been exhausted is described in § CS-450.

CS.402.1 Completion of Billing Items on Form SSA-1486

Items 16 and 17. Discharge Information. If the patient is still in the sanatorium receiving inpatient sanatorium services, extended care sanatorium services, or non-covered services, check "Still an Inpatient." Otherwise, check "Discharged" or "Did Not Recover." As appropriate, show the date of discharge or discontinuance of inpatient or extended care in item 16.

Item 18. Statement Covers Period. Show the beginning and ending days of the period covered by the bill. However, the beginning date should be no earlier than the first day of the beneficiary's date of entitlement even though the date of admission in item 11 or 12 may be before that date. For example, where the patient was admitted to inpatient sanatorium services before July 1, 1966, show 07/01/66 in the "From" item. In the "To" item, show the date of discharge or discontinuance of services because the patient did not recover. If the patient is still in the sanatorium, show the last day of the period being reported on the bill, whether or not this last day was a day of covered services.

See § CS-450 for completion of the form after benefits have been exhausted.

Item 19. Statement of Services. Either inpatient Christian Science sanatorium services or sanatorium extended care services, but not both, may be entered here. Show all charges for the period covered by the current billing for each of the departments. Show all charges--covered or non-covered--in the "Total" column. Charges for non-covered services and items are itemized in the "Non-covered" columns. If it is necessary to explain any item, a statement may be attached. Any statement attached should show the patient's name and claim number. See CS-200 for details of covered items and services.

ITEMS OF SERVICE

A. One Bed. Show the number of days in the standard one-bed accommodation and the daily rate. Multiply the days

times the rate to show the total charges.

B. Other Accommodation. If the patient had accommodations other than the standard one-bed, show the number of days and total charges. Also, show the difference between standard one-bed room charges and the other accommodation charges in the "Non-covered" column. Payment cannot be made for the difference between standard accommodations and the more expensive accommodations.

Attach to the bill a brief explanation and description of the other accommodations.

C. Other Services. Specify any services other than the room charge and show the charges. Where charges for supplies, appliances, and equipment are not based on a rate, the "No. of Days" and "Rate" columns should not be completed.

If necessary, an attachment may be used to specify these items.

D. Total. Show the total covered and non-covered charges.

Item 20. Date Guarantee of Payment or UR Notice Received.
Use this section to report either of the following.

A. The date that the sanatorium received the report of eligibility showing that the number of inpatient sanatorium days remaining was less than the number of inpatient sanatorium days already provided in the current stay.

B. The date the sanatorium received notice from the utilization review committee that the patient no longer needed sanatorium services.

Cross out the item which does not apply.

The guarantee of payment provisions does not apply unless the sanatorium establishes that it acted in good faith in assuming the individual was entitled to have payment made for sanatorium services, and acted reasonably in assuming that the patient's inpatient days had not been and were not about to be exhausted.

Where the guarantee of payment provision applies, the sanatorium should attach a statement indicating why it believes that the requirements of this provision are met.

Item 21. Date Benefits Exhausted. If the patient is still receiving inpatient sanatorium services, and no further days are available, show the last day for which benefits were payable. No entry should be made in this space when the Reply to the Notice of Admission showed that no days are available.

COMPUTATION OF CARE REIMBURSEMENT

Payments to the sanatorium under the hospital insurance plan are based on the reasonable cost of services provided. They will be established by the sanatorium and the intermediary on the basis of the sanatorium's previous cost experience. The sanatorium may wish to make a computation on its own copy of the form. If the sanatorium wishes to make a computation for its own records it can estimate the cost of covered services and subtract the applicable deductible and coinsurance to arrive at the reimbursement amount.

Item 22. Computation of Inpatient Care Reimbursement.

A. Total Covered Days.--Show the total days of inpatient sanatorium care. Count the date of admission but do not count the date of discharge from the sanatorium. Also, do not count the day of transfer when the patient is transferred from inpatient sanatorium care to non-covered care.

Multiply the number of days by the reasonable cost amount per day agreed upon by the sanatorium and the intermediary. Enter the result here.

B. Deductions.

1. Inpatient Deductible.--The inpatient deductible under the hospital plan is \$40 until 1969. The amount to be shown in this item is \$40 (unless the covered charge for the stay is less than \$40), less any deductible amount already paid by the patient in this spell of illness. The dollar amount of the \$40 deductible yet to be met for the current spell of illness will be shown on the Reply to the Notice of Admission.

2. Coinsurance.--The coinsurance period is the 61st day through the 90th day during a spell of illness. Multiply by \$10 the number of days covered by this bill which fall in this period and enter here.

C. Reimbursement Amounts.--Subtract any deductible and/or coinsurance amounts in Item 22B from the amount in item 22A. Enter the result here.

Item 23. Computation of Extended Care Reimbursement.

A. Total Covered Days.--Show the total of extended sanatorium care days up to a maximum of 30 days after December 31, 1966. Count the date of election of extended care but do not count the date of discharge from the sanatorium. Also, do not count the day of transfer when the patient transferred from sanatorium extended care to noncovered care.

Multiply the number of days or the total charges by the reasonable cost factor agreed upon by the sanatorium and the intermediary. Enter the result here.

B. Deductions.--Multiply each day of service by \$5 and enter the result here.

C. Reimbursement Amount.--Subtract the deductions (item 23B) from the amount in item 23A. Enter the result here.

Item 24. Certification.--This item acts as a certification by the sanatorium representative signing the form that verification and, if necessary, reverification of the patient's need for sanatorium services have been made and are on file. Verification and reverification will be by the Admission and Utilization Review Committee. A sanatorium representative should sign and date the form before it is submitted to the intermediary.

Item 25. Verified Prior Stay Dates and Provider Number. DO NOT USE.

CS.402.2. Disposition of Copies of Completed Forms SSA-1486.

Retain the copy designated "Sanatorium" and submit the remaining copies to your intermediary. The remaining copies to be submitted to the intermediary constitute the following:

a. The original copy which is maintained in the intermediary's files.

b. One copy designated "Social Security Administration Copy."

CS-450. PROCEDURE FOR SUBMITTING BILLING AFTER EXHAUSTION OF BENEFITS

The benefit days available to a beneficiary depend on the status of his prior utilization of services during this "spell of illness."

The days that the beneficiary receives inpatient sanatorium services after his 90-benefit days have been exhausted must be reported by the sanatorium so that the intermediary and the Social Security Administration will know when a spell of illness ends. Similarly, days of extended care services must be reported after his 30 benefit days have been exhausted.

Items 1, 2, 4, 7, 11 or 12, 13, 16, 17, and 19 (line D) are the items required on the form SSA-1486.

The sanatorium detaches the two admission copies and sends the top two copies of the form to the intermediary in the usual manner. Only one billing form need be completed for the period after benefits are exhausted, regardless of the length of time involved. This form may be completed after discharge or failure to recover.

CS.460. PROCEDURE FOR SUBMITTING CORRECTED BILLS

The sanatorium may discover that a bill already submitted is incorrect.

To correct a previously submitted bill, the sanatorium should reproduce three copies of the previously submitted bills and make the necessary corrections on two of them. The corrected copies should be marked "Debit-Adjust" in the upper right margin and the third copy should be marked "Credit-Cancel" in the upper right margin.

All copies should be submitted to the intermediary.

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1967

**HEALTH
INSURANCE
FOR THE AGED**

**HOSPITAL
MANUAL**



U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

HIM-10 (4-67)

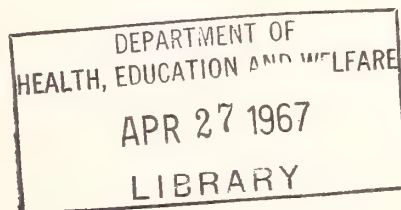
Introduction to the Revised Edition, April 1967

A significant volume of additional material has developed and there have been numerous changes since the original issuance of the Hospital Manual in June 1966. Rather than attempt a piecemeal revision, we are now issuing a replacement to supersede the original edition. Copies of the original may be discarded. An index is included with this edition.

Henceforth, we expect to make timely revisions by replacement pages which your intermediary will distribute to you, so that the manual will at all times be current and you will have in one place the definitions, instructions, and procedures you need in handling claims.

Much of the material now incorporated in the manual for the first time will not be new to you. You have previously received it through your intermediary or in flyer form. As an aid in finding new material of immediate interest to you, you should review the list of significant substantive changes, clarifications, and additions which follows. The list of changes is not exhaustive, but shows the most important. The list may be discarded when it has served its purpose.

THOMAS M. TIERNEY
Director, Bureau of Health Insurance



Chapter I

GENERAL INFORMATION ABOUT THE PROGRAM

104. Disclosure of Information.—The prohibition against disclosure of program information extends to the beneficiary's health insurance claim number and the fact of his entitlement to health insurance benefits. Disclosure of information to State welfare agencies may be made under certain conditions.

110.2 Posthospital Extended Care Services.—The day of admission, but not the day of discharge, is counted in computing the 3-day prior hospital stay.

110.3 Posthospital Home Health Services.—The 100 home health visits under Part A must be furnished after the beginning of one spell of illness and before the beginning of the next.

122.2A Beginning of Coverage.—The initial general enrollment period for Part B was extended through September 30, 1966, when there was good cause for failure to enroll timely.

122.3C2 End of Coverage.—A social security railroad retirement beneficiary, who was enrolled as a public assistance recipient and then ceases to be a public assistance recipient, may terminate his medical insurance coverage within 3 months thereafter.

Chapter II

COVERAGE OF HOSPITAL SERVICES

202. Hospital Emergency Services.—The appropriate social security regional office with medical consultation by Public Health Service makes the determination of whether an emergency existed. Notices of emergency admissions and billings by nonparticipating hospitals are submitted to the local social security district office and payment is made by intermediaries designated by the Social Security Administration.

202.1 Definition of Emergency Services.—The determination of emergency services depends upon two findings: (1) The patient's condition; and (2) the availability of facilities. Guidelines on what constitutes "the most accessible hospital" are being developed.

202.2 Termination of Emergency Services.—An emergency no longer exists when it becomes safe from a medical standpoint to move the patient.

202.3 Physician's Supporting Statements.—Details of required documentation are given.

205–205.3 Certification of Parts of Institutions as Hospitals.—The parts of institutions certifiable as participating hospitals are clarified.

206. Christian Science Sanatorium.—Sanatorium services are considered hospital services unless the individual elects extended care services. The counting of sanatorium services as inpatient benefit days is explained.

210. Covered Inpatient Hospital Services.—"Inpatient" is defined.

210.1 Accommodations.

210.1B. A hospital having only private accommodations can be paid only the equivalent of the reasonable cost of semiprivate accommodations unless the private accommodations were medically necessary. Where a patient is placed in a private room because less expensive accommodations are not available, the hospital can be reimbursed only for the reasonable cost of semiprivate accommodations. The hospital may not charge the patient for the difference unless the patient requested private accommodations with the knowledge that he would be charged the difference.

210.1C. Where a patient has been placed in accommodations less expensive than semiprivate neither at his request nor for a reason consistent with the program's purpose, payment cannot be in excess of the reasonable cost of ward accommodations. A hospital which repeatedly assigns patients to ward accommodations under such circumstances is subject to termination of its participation agreement.

210.1D. "Most prevalent rate" is defined.

210.2 Nursing and Other Services.—The cost of services of a nonphysician anesthetist is covered. Private duty nurse or attendant is defined.

210.3–210.4 Drugs and Biologicals and Supplies, Appliances and Equipment.—The material on coverage of drugs, supplies, and appliances has been considerably expanded.

210.5 Other Diagnostic or Therapeutic Items or Services.—The services of psychologists and physical therapists to inpatients are reimbursable hospital costs.

"Independent laboratory" is defined. Reasonable charges by such a laboratory for services furnished under arrangements with a hospital represent the hospital's cost for the services. The same rule applies to charges by the laboratory of another participating hospital. Independent laboratories providing services for inpatients under arrangements made by the hospital must meet all of the requirements in the law.

210.7 Inpatient Services in Connection with Dental Services.—The coverage of inpatient services in connection with dental services is explained.

215. Spell of Illness Defined.—The spell of illness begins with transfer to a qualified hospital where a patient was in a nonqualified hospital on his first day of entitlement. Admission to a qualified extended care facility will begin a spell of illness even though the services may not be paid for by the program. In determining the 60-day period for ending a spell of illness, counting begins with the day of last discharge.

216–216.4 Inpatient Hospital Benefit Days.—Inpatient benefit day is defined (§ 216.1) and rules are given for treating late discharge (§ 216.2), leaves of absence (§ 216.3), and the special situations where a patient is discharged on his first day of entitlement or on the first day the hospital participates in the program (§ 216.4).

217–217.3 Inpatient Tuberculosis and Psychiatric Restriction.—The inpatient psychiatric and tuberculosis restriction, when applicable, affects all inpatient hospital benefit days in the initial spell of illness, including those in a general hospital. Rules are provided for determining the patient's status on his first day of entitlement (§ 217.1), the effect of the institution's status in figuring the number of days to be deducted (§ 217.2), and how days of admission, discharge, and leave are treated in figuring the days deducted (§ 217.3). Days of discharge are *not* counted.

219. Inpatient Service Days Counting toward Maximums.—Inpatient days count toward the maximum even though payment cannot be made because of the inpatient deductible or coinsurance provisions.

220. Deductible.—The deductible is satisfied only by charges for covered services, and on an incurred rather than paid basis. Inpatient deductible expenses must have been incurred in the given spell of illness and expenses incurred in meeting the whole blood deductible do not count toward the inpatient deductible. The effect on deductible status and reimbursement when the customary charges are less than the deductible is explained.

222. Whole Blood Deductible.—The rules on the amount the program will pay and the amount the patient may be charged for whole blood have been amplified and clarified. Special rules are included for blood obtained by the hospital from an independent blood bank.

225. Coinsurance.—When the charge for a coinsurance day is less than \$10, the coinsurance rate is the actual charge. The example of the effect of the tuberculosis-psychiatric restriction has been revised to avoid the impression that days of hospitalization in the 90-day preentitlement period must be consecutive, and to reflect the changed position that days of discharge are not counted.

230–240.4 Outpatient Hospital Services.—The material concerning outpatient hospital services under both Part A and Part B has been amplified and completely reorganized. Much of this

material was previously issued in the flyer, "Outpatient Hospital Services Under Medicare." The reorganization makes the basic distinction between identifiable diagnostic tests provided for outpatients covered under Part A and other outpatient hospital services which aid the physician.

Specific items of interest in individual sections are noted in the following:

230. Outpatient Hospital Services—General.—"Outpatient" is defined.

230.1 Rules for Distinguishing Outpatient Hospital Services.—The rules for distinguishing outpatient diagnostic services and other outpatient services are set forth.

232.1 Types of "Arrangements."—Explains the arrangements hospitals currently maintain with other facilities for obtaining laboratory services.

232.2 and 232.3 Diagnostic Services Obtained from Laboratories.—Clarify the coverage under Part B of laboratory services obtained for hospital outpatients under arrangements with an independent laboratory or another participating hospital. In these cases the charges for the services become the cost to the hospital obtaining the services.

234. Other Outpatient Hospital Services Which Aid the Physician.—Defines and exemplifies other outpatient hospital services which aid the physician.

240. Coverage of Hospital Services Under Supplementary Medical Insurance—General.—Part B hospital services and supplies are not covered when furnished to inpatients even when the inpatient is not entitled to Part A benefits, e.g., and individual who remains an inpatient after exhausting his 90 days of inpatient services in a spell of illness.

240.1 Services of Interns and Residents.—Defines the situations in which the services of interns and residents are covered as Part B hospital costs.

240.2 Hospital Services and Supplies Incident to Physicians' Services.—Clarifies the meaning of services and supplies incident to physicians' services. The services of nonphysician anesthetists and psychologists are included as services incident to physicians' services. The required physician supervision of paramedical personnel is explained. Oxygen, and splints, casts, and other devices used for the reduction of fractures and dislocations have been included as examples of supplies incident to physicians' services.

Prosthetic devices and leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes are now included as items which are covered only when furnished incident to a physician's services. Dialysis equipment is given as an example of a prosthetic device replacing an internal body organ. The coverage of prosthetic lenses has been clarified. A definition of "brace" has been included. A terminal device such as a hand or hook is covered when an artificial arm is required by the patient. The cost of an artificial limb or appliance when furnished initially or as a replacement is covered when supplied on the order of a physician.

240.3 Use of Durable Medical Equipment.—The title and contents of this section have been changed to avoid the impression that a hospital can be paid rental for durable medical equipment. A beneficiary cannot be reimbursed for the purchase of such equipment. Oxygen used with hospital-furnished equipment in the patient's home is covered.

240.4 Ambulance Service.—Defines "locality" and otherwise clarifies the requirements for coverage of ambulance services. While transportation to a hospital to obtain home health services is not covered as a home health service, it may be covered under Part B if the specified conditions for coverage are met.

245. Incurred Expenses.—Specifies that the Part B psychiatric services limitation *does not* apply to provider services.

246. Deductible.—Bills count toward the deductible on the basis of incurred expenses; non-covered expenses and expenses incurred prior to entitlement to Part B do not count toward the deductible.

255. Hospital-Based Physicians' Services.—Defines the areas of responsibility of the Part A intermediary and Part B carrier in billing and reimbursement for the services of hospital-based physicians. The provider component of such physician services includes services in connection with autopsies.

260. General Exclusions.

260.1 Not Reasonable and Necessary.—Examples of potential comfort items are included.

260.2 No Legal Obligation to Pay.—The legal obligation to pay requirement has been clarified. The effect of various patient arrangements with homes for the aged on the application of this exclusion is explained.

260.3 Paid for by a Governmental Entity.—Covered services, even if provided free of charge, have been excepted from this exclusion when furnished by a participating State or local government-operated hospital, or a State-operated Veterans' Home and Hospital; or paid for by a State or local governmental entity for certain specified purposes. Effects on coverage of services to prisoners and services paid for by NIH grants.

260.9 Custodial Care.—Custodial care is defined.

260.11 Charges Imposed by Immediate Relatives of the Patient or Members of His Household.—"Immediate relative" and "members of the patient's household" are defined.

260.12 Dental Care.—Clarifies the various procedures which are subject to the dental services exclusion.

270.2 Request for Payment on Hospital Record.—Gives the details of the alternate signature procedure in which the hospital may arrange with its Part A intermediary to have the patient's signature on its admission records serve as the request for payment.

271. Execution of the Request for Payment.—When specimens are submitted for analysis, but the patient himself does not go to the hospital, the hospital may sign the outpatient billing form on the patient's behalf.

273.1 Failure to Obtain Certification and Recertification Statements.—Explains the effect of a physician's refusal to certify or recertify medical necessity.

274. Inpatient Hospital Services Certification.—Explains when a dentist may certify as a "physician" for hospitalization required for dental procedures.

275. Recertification for Inpatient Hospital Services.—Recertification criteria are related to the utilization review guidelines on availability of other facilities in § 290.3.

285. Refunds.—Defines money incorrectly collected.

285.1 Return or Other Disposition of Money Incorrectly Collected.—Describes the manner and time limit for refunding or setting aside money incorrectly collected.

286. Guarantee of Payment Provisions.—The guarantee of payment provision applies only to exhaustion of inpatient benefit days. The coinsurance provision does not apply to days beyond the maximum which are covered by the guarantee of payment.

286.1 Requirements for Payment Under the Guarantee.—"Good faith" and "acted reasonably" have been more precisely defined as conditions under the guarantee of payment. If the hospital retains payments made by the patient for the guarantee period, it should not bill the program for the amounts retained.

289. Workmen's Compensation.—Workmen's compensation plan is defined. The hospital should advise the patient to file for workmen's compensation where a work-related injury or illness is indicated.

289.1 Effect of Workmen's Compensation Payments on Eligibility and Spell of Illness.—Workmen's compensation coverage does not reduce the 190-day lifetime limit on inpatient psychiatric services.

289.2 General Procedures in Workmen's Compensation Cases.—The intermediary will make the determination as to reasonable expectation of payment under workmen's compensation, including lump sum settlement cases, and will notify the hospital of the effect on health insurance benefits.

289.3 Overpayments.—If workmen's compensation results in a health insurance overpayment, the hospital may make direct refund or have the amount of future payments due it adjusted.

290. Utilization Review Plan.—A hospital's utilization review committee may review an inpatient admission at any time. The decision of the committee of one hospital is not binding on the

committee of another hospital. Payments to physicians for services on the utilization review committee are an allowable hospital cost only if the hospital's utilization review plan is applicable to all of the hospital's inpatients.

290.2 Further Inpatient Stay Not Medically Necessary.—The attending physician may give the notice to his patient of the utilization review committee's decision that further inpatient stay is no longer necessary.

290.3 Availability and Appropriateness of Other Facilities and Services.—Gives guidelines for general hospital utilization review committees in determining necessity for continued hospitalization.

Chapter III

ADMISSION PROCEDURES

302.1 Certificate of Social Insurance Award or Temporary Eligibility Notice.—Describes other entitlement notices sent to beneficiaries who have not yet received their health insurance cards.

306.2 The SSA District Office Reply.—Specifies the types of response from the district office when the claim number is not available.

308. Condition is Critical or Discharge is Near.—The procedure for obtaining a health insurance application has been expanded to include cases in which the claim number is unavailable and the patient is near discharge, as well as those in which the patient's condition is critical. Additional information is included on when an application under the procedure becomes effective.

309. Intermediary Requests to Verify Patient's Health Insurance Claim Number.—Discusses hospital handling of intermediary requests to verify health insurance claim numbers when the claim numbers on notices of admission do not match the central record.

310.1 Completing Inpatient Hospital Notice of Admission, Form SSA-1453.—Includes the following substantive changes:

Item 4.—An admission notice can be transmitted where date of birth is unknown.

Item 9.—The address of the attending physician needs to be shown only where the intermediary requires it.

Item 12.—Adds information on identifying a welfare agency when charges are payable under a federally supported assistance program.

Item 13.—Adds the alternate procedure for obtaining the patient's signature on the hospital's admission records.

325. Initiating Notices of Admission Where No Payment Will Be Made.—Several other no-payment situations in which admission notices will be initiated have been included in addition to benefits exhausted cases.

330. Notices of Admission for Emergency Services in Nonparticipating Hospitals.—A new section summarizing admission and billing procedures for nonparticipating hospitals rendering emergency services.

CHAPTER IV

BILLING PROCEDURES

400. Billing Procedures—General.—Explains billing for leaves of absence and repeated discharges and admissions. Former Section 400.1, List of Authorized Signatories, has been eliminated. It will no longer be necessary for hospitals to submit the listings to their intermediaries.

402. Inpatient Hospital Admission and Billing (Form SSA-1453).—Asks for submission of bills for additional types of hospital stays for which no payment can be made but which can begin or extend a spell of illness.

402.1 Completion of Billing Items on the Form SSA-1453.

Item 17. Statement of Services.—Where charges not listed on the form are applied to one of the departments listed, all bills submitted should apply the same charges consistently to the same departments. Describes in greater detail the procedure for submitting the hospital's own billing form in lieu of the detailed completion of Statement of Services. Includes instructions for showing discounted charges.

Explains that noncovered charges should be shown in the Noncovered Charges column except where the noncovered charge is billed routinely to medicare and nonmedicare patients alike, e.g., pathologists' services included in all billings of laboratory charges. Noncovered charges cannot be applied to the deductible, even where noncovered charges are routinely billed to all patients and included in the Total Charges column.

Items A-E. Accommodations.—Accommodation days are always shown as whole rather than fractional days; gives the rules for showing late discharge charges on the billing form. Instructions are included for handling ancillary charges for day of discharge or death and where the patient is discharged on the first day of entitlement. Where there was more than one rate for a given type of accommodation, one of the unused accommodation lines may be relettered and used to show the entry.

Item 17A. One bed.—If the patient was in a one-bed accommodation for other than medical reasons, program payment cannot be made for more than semiprivate accommodations, and the patient may not be charged the difference unless he requested such accommodation. The entries to be made in the Total and Noncovered Charges columns are described.

Items 17D and E. Intensive care and self-care.—Explains billing entries where the patient is in the intensive care unit for part of a day.

Item F. Whole blood.—The explanation for the entries for Pints Furnished, Not Replaced, Charge per Pint, and Total and Noncovered Charges has been revised and expanded to take account of the expanded statement in § 222, particularly as regards blood obtained from independent blood banks.

G-O. General.—Explains how items and services which are more expensive or in excess of the services covered by the program, should be shown in the Total Charges and Noncovered Charges columns. Where the patient did not request such services, only the covered charges should be shown in the Total Charges column, and no entry made in the Noncovered Charges column. Where the patient requested such services and the hospital will bill him for them, the Total Charges column will reflect the full charge and the Noncovered Charges column will show the excess charge billed to the patient.

P. Inpatient deductible.—This line should show total charges in line "O" minus any physician's charges included in total charges.

R. Coinsurance.—In addition to the total deduction for coinsurance, the rate and the number of days should be shown. The coinsurance rate is \$10 or the daily charge, whichever is less.

Item 18. Statement Covers Period.—This item should show inclusive dates whether or not all days are covered, except that days before the patient's entitlement will not be shown. An example shows how this item is completed where the hospital bills periodically for a continuous stay.

Item 19. Total Days.—Explains what days should not be included in this item, i.e., benefits exhausted and guarantee of payment does not apply; workmen's compensation payment is made or can be expected to be made; a National Institutes of Health grant will pay; services are not covered; days on which the patient was on a leave of absence or is away from the hospital because of repeated admissions and discharges; the day of discharge or death. An explanation of noncovered days is required in the Computation of Interim Payment block.

Indicates entries to be made where an individual is admitted as an inpatient and is discharged or transferred to another hospital before midnight of the day of admission.

Item 21. Date Benefits Exhausted.—This item should not be completed unless benefits are exhausted before date of discharge or death, and during period covered by Item 18. A projected date should not be used.

Item 26. Hospital Certification and Signature Lines.—The date forwarded should be the date the bill is actually forwarded to the intermediary. The date used should not be before the “To” date in the “Statement Covers Period” item. A stamped signature is acceptable for the SSA-1453 as well as all other hospital billing forms.

All-Inclusive Rate Hospitals.—Provides billing guides for hospitals using all-inclusive rates.

410-410.2 Inpatient Psychiatric or Tuberculosis Admission and Billing (Form SSA-1485).—Revised to reflect changes made in Sections 400, 402, 402.1, and 402.2.

412-412.1 Explanation of Accommodation Furnished (Form SSA-1484).—The instruction on when the SSA-1484 is to be completed reflects the position on payment for accommodations in hospitals having only private rooms as indicated in § 210.1.

Item 6. Type of Accommodation Furnished.—Explains how to compute the most prevalent semiprivate rate.

Item 7. Reason for Assignment to Accommodation Mentioned. Eliminates from Item C, Other Reasons, an explanation for a one-bed assignment where it was not medically necessary, since program payment may not be made in such a situation.

420. Outpatient Hospital Billing (Form SSA-1483).—Explains when fully completed bills should be submitted although the hospital will not receive program reimbursement. Additional guidelines are also given for the billing of one complete diagnostic study.

420.1 Completing Items on Form SSA-1483.—Has a number of revisions on the completion of items.

Item 5. Date of Birth.—The date of birth should be shown if available. However, if it is not available, the billing form may be submitted without it.

Item 9. Name and Address of Physician Requesting Outpatient Services.—The physician’s address need not be shown unless the intermediary requires it.

Item 10. Payment Source.—If the hospital will not bill anyone for expenses not reimbursable under the program, this item need not be completed. The identifying information required if a public agency is involved will assist the intermediary in forwarding a copy of the bill to that agency, when appropriate.

Item 11. This date should be the first date the patient was seen for a diagnostic study.

Item 12. Patient’s Certification and Payment Request.—Incorporates the procedure on obtaining the patient’s signature on the hospital’s record and signature by the hospital when the patient does not visit the hospital, from §§ 270-271.

Item 14. Statement of Services.—Provides categories to be used where possible for reporting laboratory tests. Only one bill should be completed even though services were rendered by different outpatient departments. Where necessary, more than one form may be used to report the services in the same billing; the items to be completed on the additional forms are indicated.

430. Provider Billing for Patient Services by Physician (Form SSA-1554).—Explains when the SSA-1554 form will be submitted directly to the Part B intermediary, e.g., covered hospital days in a spell of illness are exhausted, or the patient receives physician services in the hospital after the utilization review committee has determined further hospitalization is not necessary. The SSA-1554 must be completed in every case where the provider takes assignment on reimbursable amounts even though the charges for physician services do not exceed the deductible amount collected. This will insure that all Part B expenses are recorded to the beneficiary’s account.

430.1 Completing Items on Form SSA-1554.—The instructions for completion of item 10 of the SSA-1554 have been changed as follows for the “optional” method:

10A. Date of Service.—Inclusive dates may be used with “optional” method.

10B. Name of Physician.—May be omitted when the “optional” method is used.

10D. Surgical or Medical Procedures.—May be omitted when the “optional” method is used and department is identified in 10E.

10F and 10G. **Total Charge and Percentage of Total Charge.**—Under the “optional” method, the total provider charge is shown in 10F and the uniform approved departmental percentage for physician’s component is shown in 10G.

430.3 Description of “Item-by-Item” and “Optional” Methods for Physicians’ Components. Defines the terms “item-by-item” and “optional” method as used in § 430.1.

450. Procedure for Submitting Inpatient Billing After Exhaustion of Benefits or When No Payments Are Due. Describes additional situations where no payment can be made, but which nevertheless call for the submission of a billing form.

460. Procedure for Submitting Corrected Bills. Requires only submission of the corrected copy of the bill. The intermediary will prepare any additional copies which are required. A tolerance rule on submission of corrected bills is given.

Health Insurance for the Aged

HOSPITAL MANUAL

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USING THE HOSPITAL MANUAL

Use It for Reference

The manual covers not only routine information for your day-to-day operations but tries to anticipate infrequent situations that could occur. It has been indexed for ease of reference.

Keep It Available

Pages are punched for any standard-size three-ring binder. Keep it handy and ask for as many extra copies as you need.

Keep It Up-to-Date

Insert or replacement pages for additions and revisions will be furnished through your intermediary. Maintain a control on all manuals to assure immediate updating.

FOREWORD

This manual is designed for use by hospitals which will be billing for services furnished under the provisions of the Health Insurance for the Aged Act of 1965. It contains informational and procedural material the hospital will need to assist in prompt and efficient payment of claims and to answer questions which patients may ask about the program. This issuance should help to assure that the law is uniformly applied nationally without regard to where covered services are furnished. The hospital's intermediary will issue any necessary additional instructions on matters which concern the relationship between hospitals and intermediaries.

The manual does not have the effect of regulations, but a careful effort has been made to insure that the provisions of the law, the regulations and proposed regulations are accurately reflected.

The procedures described in this manual have been devised to satisfy the administrative needs of the program with a minimum of inconvenience to beneficiaries, and to hospitals and their intermediaries. We believe that the vast majority of claims will lend themselves to simple, routine handling.

The manual is designed to accommodate new pages as further interpretations of the law and changes in procedures are made. Accordingly, revised sections, pages, or chapters will be issued as the need presents itself.

Your intermediary will answer any questions you may have about policies and procedures in the program. Hospitals dealing directly with the Social Security Administration may direct questions to the servicing social security district office for reply or refer them to the Bureau of Health Insurance Regional Representative.

THOMAS M. TIERNEY
Director, Bureau of Health Insurance

Chapter I

GENERAL INFORMATION ABOUT THE PROGRAM

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Chapter I

GENERAL INFORMATION ABOUT THE PROGRAM

100. INTRODUCTION

The Health Insurance for the Aged Act, Title XVIII of the Social Security Act, known as "Medicare," has made available to nearly every American 65 years of age and older a broad program of health insurance designed to assist the Nation's elderly to meet hospital, medical, and other health costs. The program includes two related health insurance programs—hospital insurance (Part A of the law) and voluntary supplementary medical insurance (Part B of the law).

The conduct of the program has been delegated by the Secretary of Health, Education, and Welfare to the Commissioner of Social Security. Congress has provided substantial administrative roles for the States and for voluntary insurance organizations in recognition of their experience in the health care and insurance fields.

The law specifically prohibits the Federal Government from exercising supervision or control over the practice of medicine, the manner in which medical services are provided, and the administration or operation of medical facilities. The patient is free to choose any qualified institution, agency, or person offering him services. The responsibility for his treatment and the control of his care remains with his physician and the hospital or other facility or agency furnishing him services. The individual may keep or obtain any other health insurance available, if he desires.

102. DISCRIMINATION PROHIBITED

Participating providers of services under the hospital insurance program, i.e., hospitals, extended care facilities, and home health agencies, must comply with the requirements of Title VI of the Civil Rights Act of 1964. Under the provisions of that Act a participating hospital is prohibited from making a distinction on the ground of race, color, or national origin in the admission and treatment of patients; the accommodations provided; the use of equipment and other facilities; and the assignment of personnel to provide services.

Title VI prohibits discrimination on the ground of race, color, or national origin in the selection by the

hospital of physicians, surgeons, dentists, or other practitioners seeking the privilege of practicing in the hospital, as well as of consultants, advisers, volunteers, and observers.

The Department of Health, Education, and Welfare is responsible for investigating complaints of non-compliance.

104. DISCLOSURE OF HEALTH INSURANCE INFORMATION

Records and information acquired in the administration of the Social Security Act are confidential and may be disclosed only under the conditions prescribed in rules and regulations or on the express authorization of the Commissioner of Social Security. The regulations of the Department of Health, Education, and Welfare regarding the confidentiality of records and information apply to governmental and private agencies participating in the administration of the program; to institutions, facilities, agencies, and persons providing services; and to those furnishing services under arrangements with a provider of services.

Information furnished specifically for purposes of a claim under the health insurance program is subject to these rules and regulations. Such information includes the individual's health insurance claim number, the fact of his entitlement to health insurance benefits, and medical and other information obtained from the Social Security Administration or an intermediary.

However, the information in the provider's own medical records of a patient is not subject to these rules and regulations even though the patient receives benefits under the health insurance program. These records are subject to the requirement of confidentiality in the "Conditions of Participation for Hospitals," and may also be subject to State or local laws or hospital rules governing disclosure.

A provider may disclose records or information acquired under the health insurance program only when the record or information is to be used in connection with a claim for health insurance benefits; and the disclosure is necessary for the proper performance of the duties of any officer or employee of (1) the Depart-

ment of Health, Education, and Welfare, or (2) any public or private agency or organization under an agreement with the Secretary of Health, Education, and Welfare.

A State agency certifying providers in the health insurance program may disclose to the State licensing authority information furnished by a hospital relating to the hospital's compliance or noncompliance with the licensure requirements. Prior approval by the Department of Health, Education, and Welfare is a condition for such disclosure.

The Social Security Administration has issued guidelines for intermediaries in arranging to supply billing information to State public welfare agencies when payment of the cost of hospitalization is to be made under both the health insurance and State welfare programs. State public welfare agencies which have entered into agreements with health insurance intermediaries will make any necessary arrangements with the hospitals involved.

110. HOSPITAL INSURANCE (PART A)

This is the basic part of the health insurance program. It is designed to help patients defray the expenses incurred by hospitalization and related care. In addition to inpatient hospital benefits, hospital insurance covers outpatient hospital diagnostic services, and posthospital care in extended care facilities. It also covers posthospital care furnished by a home health agency in the patient's home. In providing these additional benefits, recognition was given to the need for continued treatment after hospitalization and the need to encourage the use of less expensive substitutes for inpatient hospital care. Program payment for services rendered to beneficiaries by providers (i.e., hospitals, extended care facilities, and home health agencies) may be made only to the provider, and is based on the reasonable cost of the covered services furnished.

110.1 Hospital Services Covered Under Hospital Insurance.—Hospital services covered under hospital insurance include inpatient hospital services and outpatient hospital diagnostic services. These benefits and the applicable deductibles, coinsurance, limitations, and exclusions are fully treated in chapter II of this manual. What follows in this section is a brief description of the other covered services under hospital insurance.

110.2 Posthospital Extended Care Services.—In each spell of illness (as defined in chapter II) payment may be made for the reasonable cost of up to 100 days of posthospital extended care services, except that the patient is responsible for \$5 per day after the 20th

day. The beneficiary must have been a hospital inpatient for at least 3 consecutive days (counting the day of admission but not the day of discharge) and be admitted to the extended care facility within 14 days after the date of hospital discharge. (Benefits for posthospital extended care are payable for services furnished on or after January 1, 1967. The hospital discharge must have occurred after June 30, 1966, or on or after the first day of the month in which the beneficiary attains age 65, whichever is later.)

An extended care facility provides skilled nursing care and related services for patients who require medical or nursing care; or rehabilitation services for injured, disabled, or sick persons. It may be either a separate institution (e.g., a nursing home) or a part of an institution (e.g., a convalescent wing of a hospital). It must be licensed or approved under State or local law, meet the health and safety conditions prescribed by the Secretary of Health, Education, and Welfare, and have a written transfer agreement with one or more participating hospitals providing for the transfer of patients between the hospital and the facility, and for the interchange of medical and other information. If an otherwise qualified extended care facility has attempted in good faith but without success to enter into a transfer agreement, this requirement may be waived by the State agency described in § 132.

A facility which is primarily for the care and treatment of mental disease or tuberculosis is excluded from the definition of extended care facility.

Extended care services include room and board; skilled nursing care by or under the supervision of a registered nurse; physical, occupational, or speech therapy; medical social services; and other services ordinarily furnished by the facility. No payment may be made for custodial care or for items or services which would not be covered in a hospital.

The services of residents and interns of a hospital with which the facility has a transfer agreement and other diagnostic and therapeutic services furnished by such a hospital are covered, but only if billed through the extended care facility.

110.3 Posthospital Home Health Services.—Home health services under hospital insurance include up to 100 home health visits, after the beginning of one spell of illness and before the beginning of the next, furnished a patient within 1 year of his most recent discharge from a hospital of which he was an inpatient for at least 3 consecutive calendar days. If, after his hospitalization, he had a covered stay in an extended care facility, the 1 year during which the patient may

receive home health services begins with the discharge from the extended care facility. A plan of treatment must be established within 14 days after the hospital or extended care facility discharge. Home health services are provided also under supplementary medical insurance. (For the latter see § 115.)

The patient receiving posthospital home health services must be confined to his home and under the care of a physician who establishes and periodically reviews the plan for his patient's care. To be covered the services must be required by a condition for which the patient required inpatient hospital services or extended care services. Discharge from the required period of hospitalization must have occurred after June 30, 1966, or on or after the first day of the month in which the patient attains age 65, whichever is later.

Home health services are services provided by a home health agency or by others under arrangements with such an agency. A home health agency is a public agency or private organization which is primarily engaged in providing skilled nursing and other therapeutic services. Where applicable, the agency must be licensed under State or local law, or be approved by the State or local licensing agency as meeting the licensing standards. Examples of home health agencies are visiting nurse associations, official health agencies, and hospital-based home care programs.

To participate in the health insurance program a home health agency must meet certain other requirements included in the law as well as health and safety conditions prescribed by the Secretary of Health, Education, and Welfare. It may **not** qualify under **hospital** insurance, however, if it is primarily engaged in the treatment of mental diseases.

These services are usually furnished on a visiting basis in a place of residence used as the individual's home. However, outpatient services in a hospital, extended care facility, or rehabilitation center are covered home health services, if arranged for by a home health agency, when equipment is required that cannot be made available in the patient's home.

Covered home health services include part-time nursing care by or under the supervision of a registered professional nurse; physical, occupational, or speech therapy; medical social services; certain services of a home health aide; medical supplies (other than drugs and biologicals); and the use of medical appliances. The cost of housekeepers, food service arrangements, and transportation to outpatient facilities is excluded as home health services.

The services of an intern or resident are covered if the agency and hospital are affiliated or under common control and the agency bills for the services.

115. SUPPLEMENTARY MEDICAL INSURANCE (PART B)

The voluntary medical insurance plan is designed to supplement the basic hospital insurance coverage. It provides coverage for the expense of physicians' services, including surgery, consultation, and home, office, and institutional calls. (Physician services do not include the services provided by an intern or resident.)

Medical insurance covers home health services for up to 100 visits during the calendar year (in addition to the visits covered under hospital insurance) but without the requirement of prior inpatient care.

The plan provides coverage for services and supplies (including drugs and biologicals which cannot be self-administered) furnished incident to a physician's professional service of a type usually furnished in a physician's office and usually rendered without charge or included in the physician's bill.

See §§ 230-234 and 240 ff., "Hospital Services Under Supplementary Medical Insurance" for a fuller discussion, including additional items and services included in this part of the program for which hospitals may be reimbursed, and for the medical insurance deductible and coinsurance.

The amount of payment for covered services rendered by other than providers under the medical insurance plan is determined by the designated medical insurance intermediary on a **reasonable charge** basis. Payment is made to the beneficiary unless the physician or other supplier of services has accepted an assignment, in which case payment is made to the physician or supplier. In determining the reasonableness of charges, Part B carriers take into consideration the customary charges of the physician (or other person rendering the service) as well as the prevailing charges which are generally made in the locality for similar services. A charge is **not** reasonable if it is higher than the charge applicable for a comparable service and under comparable circumstances to the intermediary's own policyholders or subscribers.

Reimbursement to a provider for services covered by the medical insurance plan is made by the provider's (Part A) fiscal intermediary on a reasonable cost basis. In cases where the provider has elected to deal directly with the Government, the provider will be re-

imbursed by the Social Security Administration for services covered by medical insurance.

Payment for the services of hospital-based physicians (other than interns and residents) rendered to individual beneficiaries is made by the medical insurance (Part B) carrier designated to make payment for physicians' services.

120. ENTITLEMENT TO HOSPITAL INSURANCE

A. An individual is **automatically** entitled to hospital insurance beginning with the first day of the month he attains age 65 if he has **applied for** and been determined to be entitled to monthly social security benefits (although he may not actually be receiving benefit payments; e.g., he has not retired). Automatic entitlement also extends to qualified beneficiaries under the Railroad Retirement Act. (For social security purposes, a person attains age 65 on the day before his 65th birthday. Example: If birth date is August 1, attainment date is July 31, and health insurance entitlement date is July 1.)

An individual entitled to hospital insurance may also be enrolled in a health plan administered by the Civil Service Commission. In such a case the provider bills medicare. The beneficiary should contact the Federal health benefits carrier for complementary benefits.

A social security applicant who applies for monthly benefits after the month he reaches age 65 is entitled to retroactive hospital insurance benefits beginning with the first month in which he had attained age 65 and met all the requirements for monthly benefits, but not for more than 12 months before the month in which he filed his application.

Entitlement to hospital insurance benefits ends with the month the individual ceases to be entitled to social security monthly benefits or ceases to be a qualified railroad beneficiary (for example, a woman whose wife's benefits are terminated by divorce). A person who ceases to be a social security or railroad retirement beneficiary but who meets the requirements of the special transitional provision described below may reinstate his hospital insurance by filing a proper application under the transitional provision.

Hospital insurance coverage continues for the month of death, although no monthly cash benefits are payable for the month of death.

B. A special **transitional** provision in the law permits persons 65 years of age and over, who cannot qualify for monthly social security or railroad retirement benefits, to obtain hospital insurance upon filing

application. Such an individual must be a resident of the United States and either a citizen or an alien lawfully admitted for permanent residence who has resided in the United States continuously for 5 years. He may not be an active or retired Federal employee (or spouse of one) who is or could have been covered by the Federal Employees Health Benefit Act of 1959. He may not have been convicted of a crime against the security of the United States.

For coverage under the transitional provision, a person attaining age 65 after 1967 must have three quarters of coverage for each year elapsing between 1965 and the year in which he attains age 65.

Hospital insurance under the transitional provision can also be retroactive for as many as 12 months before the month of application, provided the individual meets all the other requirements during the period of retroactivity.

122. ENTITLEMENT TO SUPPLEMENTARY MEDICAL INSURANCE

A. **Enrollment.**—To obtain supplementary medical insurance coverage an individual must voluntarily enroll in the plan and pay the required premiums. He may enroll if he is entitled to hospital insurance benefits or, if he is age 65, a resident of the United States, and either a citizen or an alien admitted for permanent residence. Active or retired Federal employees and their spouses are eligible to enroll whether or not covered under the Federal Employees Health Benefit Act. (For social security purposes an individual attains age 65 on the day before his 65th birthday.)

By agreement States may enroll in the supplementary medical insurance plan eligible individuals who are receiving money payments under certain public assistance programs. Such persons who are entitled to monthly social security or railroad retirement benefits may be included at the option of the State.

B. **Enrollment Periods.**—Enrollment is possible only during specified enrollment periods.

1. During the **initial general enrollment period** an opportunity to enroll was afforded to all eligible persons age 65 and over before March 1, 1966. This enrollment period ended May 31, 1966. (An eligible individual who for good cause failed to enroll before June 1, 1966, could have enrolled before October 1, 1966.)

2. For persons first eligible on or after March 1, 1966, the **initial enrollment period** is 7 months. It begins 3 calendar months before and ends 3 calendar months after the month in which the individual first meets all enrollment requirements.

3. **General enrollment periods** occur October 1 through December 31 of each odd-numbered year beginning with 1967. Those who failed to enroll during their initial enrollment periods and those whose enrollment has terminated may enroll in these periods.

4. **States which desire to enroll eligible individuals receiving public assistance** must request coverage before January 1968, and enter into an agreement with the Government.

An individual who fails to enroll for medical insurance within the 3-year period after the close of his initial enrollment period may not enroll thereafter.

An individual whose enrollment has terminated may re-enroll only once—in a general enrollment period which begins within 3 years after the termination of his prior enrollment.

Payment may be made for covered services if the individual was enrolled at the time the services were furnished, even though at the time the request for payment is filed with the intermediary his enrollment had been terminated.

122.1 Premiums.—Initially, the premium is \$3 per month. The law permits the Secretary of Health, Education, and Welfare to adjust the premium amount in accordance with changes in medical and other costs. No change in the premium is permitted before 1968, and changes thereafter can be no oftener than every 2 years. To take into account the higher cost of insuring older individuals, premiums payable by a person who enrolls after the first enrollment period open to him, or who re-enrolls after his initial enrollment was terminated, are increased by 10 percent for each year he could have been but was not enrolled.

A grace period has been provided for payment of premiums. This period extends for 2 calendar months after the month in which the premium is due.

Persons enrolled for medical insurance and receiving social security, railroad retirement, or civil service retirement benefits (except those enrolled by the State as public assistance recipients) will have the premiums withheld from their monthly checks. The State pays the premiums for the public assistance recipients it enrolls.

Other enrollees must make premium payments directly to the Social Security Administration. Enrollees who make direct premium payment will generally be billed quarterly. However, organizations, employers, unions, etc., may under certain conditions pay premiums for their members as a group.

122.2 Beginning of Coverage

A. Enrollment during the initial general enrollment period—coverage began July 1, 1966. An individual who attained age 65 prior to March 1966, and who, on establishing good cause for failure to enroll timely, enrolled from June 1, 1966, through September 30, 1966, has coverage beginning the first day of the sixth month after the month in which he enrolled.

B. Enrollment during an entitled individual's initial enrollment period—coverage begins:

1. First day of the month in which the individual becomes age 65, if he enrolls **before** the month that he becomes 65.

2. First day of the month following the month that he becomes age 65, if he enrolls **in** the month that he becomes 65.

3. First day of the second month after the month of enrollment, if he enrolls in the month **after** he becomes age 65.

4. First day of the third month after the month of enrollment, if he enrolls **more than 1 month after** the month in which he became age 65. (However, individuals who became age 65 in March 1966, and enrolled in May 1966, have coverage effective July 1, 1966.)

C. Enrollment during one of the general enrollment periods—coverage begins the following July 1st.

D. Enrollment by a State of its welfare recipients—coverage begins on the latest of the following but not later than January 1, 1968:

1. July 1, 1966;

2. First day of the third month after the month of the agreement with the State;

3. First day of the first month in which the individual is both eligible and a member of the group;

4. The date specified in the agreement.

122.3 End of Coverage

A. An individual whose medical insurance premiums are being deducted may notify the Social Security Administration in writing during a general enrollment period that he no longer wants medical insurance. His coverage period will be terminated with the close of the year in which his notice is submitted.

B. Enrollment under medical insurance is terminated because of nonpayment of premiums. Termination is effective with the end of the grace period provided for payment of premiums.

C. If an individual is enrolled under a Federal-State agreement, his coverage under the agreement ends on whichever of the following first occurs:

1. The end of the month in which he becomes ineligible (as determined by the State) for welfare money payments; or

2. The end of the month before the first month for which he becomes entitled to monthly social security or railroad retirement benefits, unless the State exercises its option to enroll its welfare recipients who are entitled to such benefits.

If an individual's coverage under a Federal-State enrollment agreement is terminated, his coverage continues without interruption subject to the applicable premium payment requirements.

A social security or railroad retirement beneficiary or civil service annuitant who was enrolled under a State agreement and thereafter ceases to be a public assistance recipient may terminate his enrollment during the 3-month period after the month he leaves the public assistance rolls.

D. If not otherwise terminated, coverage ends with the beneficiary's death.

130. FEDERAL GOVERNMENT ADMINISTRATION OF THE HEALTH INSURANCE PROGRAM

The Department of Health, Education, and Welfare has been given overall responsibility for administration of the hospital insurance and voluntary supplementary medical insurance programs. Three major agencies of the Department—the Social Security Administration, Public Health Service, and Welfare Administration—are involved.

130.1 The Social Security Administration has the responsibility for policy formulation and the general management and operational aspects of the program. Briefly, these include: determination of the individual's entitlement to benefits and the nature and duration of services for which benefits may be paid; establishment, maintenance, and administration of agreements with State agencies, providers of services and intermediaries; in consultation with the Public Health Service and the Welfare Administration, the formulation of major policies regarding conditions of participation for providers; the development and maintenance of statistical research and actuarial programs; and the general financial management of the program. The Administration also makes determinations of reasonable costs and amounts to be paid to providers who have elected to deal directly with the Government.

130.2 The Public Health Service has the principal responsibility for the professional health aspects of the program. These include: professional consulta-

tion and recommendation to the Social Security Administration in development of health and safety, and other guidelines for determining whether providers of services meet the conditions for participation under the program; consultation and advice to State agencies concerning the application of standards for providers, and in the coordination of program activities with other health services and activities in the State; and activities necessary in studying the utilization of hospital and other medical care services under the program.

130.3 The Welfare Administration has the primary role in hospital and medical insurance program planning, coordination, and evaluation in matters that affect other federally aided assistance programs; in assisting State agencies to achieve a coordinated approach with other medical care plans under the Social Security Act; and in all aspects of program administration affecting public welfare agencies.

131. ADVISORY GROUPS

The law provides for the appointment of two non-governmental advisory groups to assist the Secretary.

131.1 The Health Insurance Benefits Advisory Council, consisting of persons outstanding in hospital, medical, and other health activities, and at least one representative of the general public, advises the Secretary on general policy in administering the program and in the formulation of regulations. The Secretary must consult with the Council in determining conditions of participation for hospitals and other providers of services in addition to the requirements specifically enumerated in the law.

131.2 The National Medical Review Committee is to be selected from people who are representative of professional organizations and associations in the field of medicine and other individuals who are outstanding in the field of medicine or in related fields. At least one member will represent the general public and a majority of the committee are to be physicians. The committee studies the utilization of hospital and other medical services under the program and makes any recommendations to the Secretary and to Congress that it considers appropriate.

132. STATE AGENCIES

The States are accorded important administrative functions to the extent that each is willing and able to undertake them by agreement with the Secretary.

A. Certifications are made by State agencies to the Department of Health, Education, and Welfare indicating whether hospitals, extended care facilities,

home health agencies, and independent laboratories meet and continue to meet their respective conditions of participation. This function is intended to be a natural adjunct to ongoing State activities, such as licensing of health facilities and other standard setting activities.

B. Consultation services are rendered by State agencies if their agreements provide for it. Consultation with hospitals, extended care facilities, and home health agencies that need and request assistance to meet the conditions of participation is an integral part of the certification process.

C. Coordination by the State relates its activities in the performance of its functions under the program to the various other programs in the State that have to do with payment for health care, quality of care, and distribution of health facilities. Coordination of such activities is designed to utilize existing State facilities and trained personnel effectively and economically and to prevent duplication of effort.

D. State Agency as a Medical Insurance Intermediary.—Where a State enters into an agreement with the Government to pay the medical insurance premium on behalf of its aged welfare recipients, as explained in § 122A the agreement may provide for a designated State agency to serve as an intermediary on behalf of its welfare recipients.

135. HOSPITAL INSURANCE INTERMEDIARIES

Under the hospital insurance plan, groups or associations of providers, on behalf of their members, may nominate a national, State, or other public or private agency, or organization to serve as intermediary in the claims process. A member of an association is free, however, to receive payment from an approved intermediary other than its association's nominee, if agreeable to the Social Security Administration and to the intermediary selected. A provider may deal directly with the Social Security Administration.

The law permits the Administration to enter into an agreement with a nominated organization if it finds this to be consistent with effective and efficient administration of the hospital insurance program. The intermediary makes payments to providers for covered items and services on the basis of reasonable cost determinations and assists in the application of safeguards against unnecessary utilization of covered services. The agreement may also call for furnishing consultative services to assist providers to establish and maintain necessary fiscal records and otherwise qualify as providers of services; serving as a center for commu-

nicating with providers; and making audits of provider records.

Generally speaking, the Social Security Administration will utilize the services of the hospital insurance intermediary in making payments for hospital and other provider services under medical insurance.

See § 255 for the hospital insurance intermediary's role in making payment determinations for services of hospital-based physicians.

137. MEDICAL INSURANCE CARRIERS

The law requires the Secretary to enter into contracts with carriers selected to serve as intermediaries for the performance of specified administrative functions under the medical insurance program. Carriers are generally assigned to serve a geographical area in which medical services are furnished. However, railroad retirement beneficiaries are served by The Travelers Insurance Company regardless of where services are furnished, and welfare recipients may be served by a State welfare agency. The principal function of this intermediary is to determine whether physicians' (including hospital-based physicians, see §§ 255 and 430) charges are reasonable and to make payment. Section 132D of this chapter explains the conditions under which a State agency may act as a supplementary medical insurance intermediary.

140. FINANCING HOSPITAL INSURANCE PROGRAM

The hospital insurance program is financed through separate payroll contributions paid by employees, employers, and self-employed persons. The proceeds are earmarked for the Federal Hospital Insurance Trust Fund to keep them separate from other social security contributions. The law permits their use only for the payment of hospital insurance benefits and administrative expenses. The cost of providing hospital insurance benefits to persons who are not social security or railroad retirement beneficiaries is met by appropriations to the Federal Hospital Insurance Trust Fund from general revenues.

142. FINANCING SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

The supplementary medical insurance plan is financed by the monthly premiums of those who enroll under the plan, matched by an equal contribution from general revenues. All premiums and Government contributions for this plan are placed in a separate fund known as the Federal Supplementary Medical Insurance Trust Fund. This fund is devoted exclusively to the payment of medical insurance benefits and administrative expenses.

Chapter II

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Chapter II

COVERAGE OF HOSPITAL SERVICES

Definitions

200. HOSPITAL DEFINED

A **Hospital (Other Than Tuberculosis or Psychiatric)** is an institution which:

a. is primarily engaged in providing to inpatients, by or under the supervision of physicians,

(1) diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or

(2) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

b. maintains clinical records on all patients;

c. has bylaws in effect concerning its staff of physicians;

d. requires that every patient must be under the care of a physician;

e. provides 24-hour nursing service by or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;

f. has in effect a hospital utilization review plan;

g. is licensed or is approved by the State or local licensing agency as meeting the standards established for such licensing;

h. meets other health and safety requirements of the Secretary of Health, Education, and Welfare. (These additional requirements may not be higher than comparable ones prescribed for accreditation by the Joint Commission on Accreditation of Hospitals with certain exceptions specified in the law.)

i. is not primarily for the care and treatment of mental diseases or tuberculosis.

201. PARTICIPATING HOSPITAL

Payment may ordinarily be made only to a participating hospital for covered services furnished by the hospital or by others under arrangements with the hospital. A participating hospital is an institution approved by the Social Security Administration which has entered into an agreement with the Administration

not to charge any patient or other person for covered items and services, except deductibles and coinsurance amounts; to return any money incorrectly collected; and to provide services on a nondiscriminatory basis in compliance with Title VI of the Civil Rights Act of 1964.

202. HOSPITAL EMERGENCY SERVICES

A nonparticipating hospital is one which does not have an agreement to participate whether or not it meets the other requirements for participation. Such a hospital, however, may receive payment for inpatient hospital services or outpatient hospital diagnostic services furnished by it, or by others under arrangements with it, if:

a. the services are **emergency services**; and

b. the services are covered services under **hospital insurance**; and

c. the hospital meets the definition of a hospital, psychiatric hospital, or tuberculosis hospital (but it need not meet the utilization review plan and the health and safety conditions prescribed by the Secretary); and

d. the hospital agrees **on an individual case basis** not to charge the patient or other person for items or services covered by hospital insurance except deductibles and coinsurance amounts; and to return any money incorrectly collected.

Notices of admission and bills will be submitted to the local social security district office (see § 330). The determination of whether an emergency existed will be made by the appropriate Social Security Administration regional office with necessary medical consultation furnished by the Public Health Service. Payment of claims for emergency services will be made by intermediaries designated by the Social Security Administration.

Emergency services outside the United States are covered under limited conditions arising ordinarily only in border areas. Payment for emergency **inpatient hospital services** furnished outside the United States may be made if the individual was physi-

cally present in the United States at the time the emergency arose and the foreign hospital was substantially more accessible than the nearest U.S. hospital which was adequately equipped and available to treat the condition. Notices of admission and bills will be processed in the same manner as indicated above.

202.1 Definition of Emergency Services.—Under the health insurance program, emergency services are those outpatient hospital diagnostic services and inpatient hospital services which are necessary to prevent the death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital available and equipped to furnish such services.

Thus, the determination of emergency services depends upon two separate findings—

1. that an emergency existed with regard to the patient's condition; and
2. that diagnosis or treatment was given at the most accessible hospital available and equipped to furnish such services.

The finding of whether the patient's condition required emergency diagnosis or treatment will ordinarily be based on the physician's evaluation of the incoming patient's condition immediately upon his or her arrival at the hospital. When the examination and diagnosis of the patient is undertaken because his apparent condition is such that failure to do so immediately might threaten his life or result in serious impairment of his health, the patient may be found to require emergency examination and diagnosis. Similarly, when the attending physician in the emergency or accident room determines that the individual should be admitted to the hospital as an inpatient to prevent death or serious impairment of health, it may be determined that emergency inpatient diagnosis or treatment was required.

In some instances the emergency nature of the situation may have been assessed by a physician who attended the patient at the place where the incident necessitating hospitalization occurred (e.g., in the case of a heart attack or an automobile accident). In these cases, the attending physician who ordered the hospitalization may substantiate the fact that emergency hospitalization was necessary.

Guidelines on what constitutes "the most accessible hospital available and equipped to furnish the necessary services" are being developed and will be made available when completed.

202.2 Termination of Emergency Services.—Since payment can be made to a nonparticipating hospital only for **emergency services**, no payment can be made to such an institution for services rendered after the emergency has ended. An emergency no longer exists when it becomes safe from a medical standpoint to move the patient to a participating institution, or to discharge him, whichever occurs first. The determination that an emergency has ended will ordinarily be based upon the physician's supporting statement, discussed below, and, when appropriate, additional data furnished by the hospital, e.g., from the patient's medical record.

202.3 Physician's Supporting Statements.—Claims filed by a nonparticipating hospital for emergency services payment must be accompanied by a physician's statement describing the nature of the emergency and stating that the services rendered were necessary to prevent the death of the individual or the serious impairment of his health. A bare statement that an emergency existed is not sufficient.

The statement should describe the nature of the emergency, furnish relevant clinical information about the condition of the patient, and also state that the services rendered were required as emergency services as defined above. It must be sufficiently comprehensive to support a finding that an emergency existed. In addition, when inpatient services are involved, the statement must include the date when, in the physician's judgment, the emergency ceased.

Most emergencies will be of relatively short duration so that only one bill will be submitted in a case. Thus, generally only one physician's statement will be necessary. However, in the rare situation where an emergency exists over an extended period, requests for payment following the initial one are to be accompanied by a physician's statement containing sufficient information to indicate clearly that the emergency situation still existed. A bare statement that the emergency continues to exist would not be acceptable.

Additional information to support a finding that the services furnished were emergency services may be requested from the physician, the hospital, and others.

203. TUBERCULOSIS HOSPITAL

A tuberculosis hospital is an institution which is primarily engaged in providing by or under the supervision of a physician, medical services for the diagnosis and treatment of tuberculosis. To be eligible for participation in the program as a tuberculosis hospital, it must be accredited by the Joint Commission on Accreditation of Hospitals, have in effect a utilization

review plan, and comply with additional staffing and medical record requirements necessary to carry out an active program of treatment and intensive care. (See "Conditions of Participation for Hospitals.")

204. PSYCHIATRIC HOSPITAL

A psychiatric hospital is an institution which is primarily engaged in providing by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons. To be eligible for participation in the program as a psychiatric hospital, it must be accredited by the Joint Commission on Accreditation of Hospitals, have in effect a utilization review plan and comply with additional staffing and medical record requirements necessary to carry out an active program of treatment and intensive care. (See "Conditions of Participation for Hospitals.")

205. CERTIFICATION OF PARTS OF INSTITUTIONS AS HOSPITALS

Under certain conditions a distinct part of a psychiatric or tuberculosis institution may be certified as a psychiatric, tuberculosis, or general hospital.

205.1 Part of a Psychiatric or a Tuberculosis Institution as a Psychiatric or Tuberculosis Hospital.—A distinct part of a psychiatric or tuberculosis institution can be certified as a psychiatric or tuberculosis hospital if it meets the conditions of participation even though the institution of which it is a part does not. If the distinct part meets requirements equivalent to the accreditation requirements of the JCAH, it can qualify under the program even though the institution itself is not accredited.

205.2 General Hospital Facility of Psychiatric or Tuberculosis Hospital.—A general hospital facility within a psychiatric or tuberculosis hospital may be certified as a general hospital independent of the institution as a whole provided the general facility is a self-contained operational entity distinct from the rest of the institution. The general hospital facility would be regarded as a separate institution for this purpose since the law does not provide for certifying a "distinct part" of an institution as a general hospital.

Services furnished in a separately certified general hospital facility are not subject to any of the benefit limitations applicable to the other parts of the institution, i.e., the reduction in benefit days in the first spell of illness in the case of psychiatric and tuberculosis hospitals (§ 217) and the 190-day lifetime maximum on inpatient services in the case of psychiatric hospitals (§ 218).

205.3 Part of a General Hospital as a Psychiatric or Tuberculosis Hospital.—There is no provision for a psychiatric or tuberculosis wing of a general hospital to be certified as a psychiatric or tuberculosis hospital. The distinct part provisions apply only to psychiatric and tuberculosis institutions and not to general hospitals.

A psychiatric or tuberculosis facility which is part of a general hospital or a large medical center or complex will be included within the certification of the overall institution unless the psychiatric or tuberculosis facility operates as a separate functioning entity, i.e., it is located in a separate building, wing, or part of a building, has its own administration, and maintains separate fiscal records.

206. CHRISTIAN SCIENCE SANATORIUM

A **Christian Science sanatorium** operated or listed and certified by the First Church of Christ, Scientist, Boston, Mass., qualifies as both a **hospital** and **extended care facility**. Sanatorium services are considered to be furnished by a sanatorium in its capacity as a hospital unless the individual elects to have them treated as sanatorium extended care services. Inpatient care in such an institution whether as hospital services or extended care services can begin or prolong a "spell of illness" (§ 215).

Payment may be made to a participating sanatorium for as many as 120 days of covered Christian Science care in the same spell of illness—up to 90 days under the hospital provision and up to 30 days under the extended care provision. Payment for sanatorium extended care services may not be made for more than 30 days in each spell of illness, instead of the 100 days applicable to extended care services generally.

Payment can be made in the same spell of illness for both inpatient hospital services furnished in a hospital and those furnished by a sanatorium in its capacity as a hospital, but the total days of covered care cannot exceed the maximum of 90 days in a spell of illness (§ 216).

Payment may not be made for sanatorium extended care services after an individual has been furnished posthospital inpatient extended care services during the same spell of illness in a qualified extended care facility other than a Christian Science sanatorium. Similarly, payment may not be made for posthospital extended care services furnished to an inpatient of an extended care facility other than a Christian Science sanatorium after he has been furnished, during the same spell of illness, covered sanatorium extended care services.

207. UNDER ARRANGEMENTS

A hospital may make arrangements with others to furnish covered items or services. When such arrangements are made, receipt of payment by the hospital for the services (whether it bills in its own right or on behalf of those furnishing the services) must relieve the beneficiary or any other person of further liability.

There are additional special requirements on furnishing items and services under arrangements. These depend on the type of hospital service involved:

- a. For inpatient hospital services, see §§ 210 ff.
- b. For outpatient diagnostic services, see § 232 ff.
- c. For hospital services under medical insurance, see §§ 240 ff.

Inpatient Hospital Services

210. COVERED INPATIENT HOSPITAL SERVICES

Patients covered under hospital insurance are entitled to have payment made on their behalf on a reasonable cost basis for inpatient hospital services. An **inpatient** is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. A person is considered an inpatient if formally admitted as an inpatient with the expectation that he will remain at least overnight and occupy a bed even though it later develops that he can be discharged, or is transferred to another hospital and does not actually use a hospital bed overnight. For billing of outpatient services furnished before admission as an inpatient see § 400.

(If a patient receives items or services in excess of, or more expensive than, those for which payment can be made, payment will be made only for the reasonable cost of the covered items or services. This provision applies not only to inpatient services but to all hospital services under Parts A and B of the program.)

§§ 210.1–210.7 discuss coverage of inpatient hospital services (including psychiatric and tuberculosis hospital services).

210.1 Bed and Board in Semiprivate Accommodations.—Hospital insurance will pay for the reasonable cost of semiprivate accommodations (two-, three-, or four-bed accommodations). When accommodations other than semiprivate are furnished, the following rules will govern.

A. Private Rooms Medically Necessary.—Payment may be made for the reasonable cost of a private room or other accommodations more expensive than semiprivate only when such accommodations are medically necessary. Private rooms will be considered med-

ically necessary when the patient's condition requires him to be isolated for his own health or that of others.

The term isolation may apply when treating a number of physical and mental conditions. These include communicable diseases which require isolation of the patient for certain periods. Privacy may also be necessary for patients whose symptoms or treatment are likely to alarm or disturb others in the same room.

Payment will also be made for the use of **intensive care** facilities where medically indicated.

B. Private Rooms Not Medically Necessary.—When accommodations more expensive than semiprivate are furnished the patient because, at the time of admission, less expensive accommodations are not available, the program may pay only the reasonable cost of semiprivate accommodations. If the patient is admitted to a hospital which has only private accommodations, and no semiprivate rooms or wards exist, the program may pay only the equivalent of the reasonable cost of semiprivate accommodations, unless private accommodations were medically necessary.

When accommodations more expensive than semiprivate are furnished the patient **at his request** in the absence of medical necessity, the hospital may charge the patient no more than the difference between the customary charges for the accommodations furnished and the customary charges for semiprivate accommodations at the most prevalent rate at the time of admission. No such charge may be made to the patient unless he requested the more expensive accommodations with the knowledge that he would be charged the differential. (See D below for definitions of "customary charges" and "most prevalent rate.")

C. Wards.—When accommodations less expensive than semiprivate are furnished **at the patient's request or for a reason determined to be consistent with the purposes of the health insurance program**, payment may be made for the reasonable cost of the accommodations furnished. It is considered to be consistent with the program's purposes to furnish bed and board in less expensive accommodations where semiprivate accommodations are not available. However, the patient must be moved to semiprivate accommodations when they become available. (Payment to hospitals which have **only** ward accommodations will be made on the basis of the reasonable cost of the accommodations furnished.)

In some cases, a patient is placed in accommodations less expensive than semiprivate **neither at his request nor for a reason consistent with the program's purposes**. It is not consistent with the purposes of

the law to assign a patient ward accommodations on the basis of his social or economic status, his national origin, race, or religion, or his entitlement to benefits as a medicare patient, or any other discriminatory reason, when the patient has not requested such assignment. A hospital which repeatedly assigns patients to accommodations less expensive than semiprivate neither at the patient's request nor for reasons consistent with the purposes of the program will be subject to termination of its participation agreement.

When ward accommodations are furnished neither at the patient's request nor for a reason consistent with the program's purpose, reimbursement will be made at a reduced rate. The payment will be the reasonable cost of semiprivate accommodations minus the difference between the institution's customary charges for semiprivate accommodations at the most prevalent rate (see D below) at the time of the patient's admission and the charge customarily made for the accommodations furnished the patient by the institution. (For example, the reasonable cost of semiprivate accommodations is \$40 per day. The most prevalent customary charge rate for a semiprivate room was \$42 per day and \$35 per day the customary charge for ward accommodations. The hospital would be paid \$33 per day for the ward accommodations, i.e., \$42 minus \$35 equals \$7; \$40 minus \$7 equals \$33.) However, payment cannot be more than the reasonable cost of ward accommodations regardless of the amount indicated by the use of this formula. The reduction in payment, when appropriate, will be made at the end-of-year settlement.

D. Customary charges means amounts which the hospital is uniformly charging patients currently for specific services and accommodations. The **most prevalent rate** for semiprivate accommodations is the rate which applies to the greatest number of semiprivate beds.

210.2 Nursing and Other Services.—Nursing and other related services, use of hospital facilities, and medical social services ordinarily furnished by the hospital for the care and treatment of inpatients are covered.

If the hospital engages the services of a nurse or other nonphysician anesthetist (either on a salary or fee-for-service basis) under arrangements which provide for billing to be made by the hospital, the cost of the service when provided to an inpatient is covered under Part A.

NOTE: The services of a private-duty nurse or other private-duty attendant are not covered. Private-duty nurses or private-duty attendants are

registered professional nurses, licensed practical nurses, or any other trained attendant whose services are rendered to and restricted to a particular patient by arrangement between the patient and the private-duty nurse or attendant.

210.3. Drugs and Biologicals.—Drugs and biologicals for use in the hospital, which are ordinarily furnished by the hospital for the care and treatment of inpatients, are covered.

Two basic requirements must be met for a drug or biological furnished by a hospital to be included as a covered hospital service. The drug or biological must (1) represent a cost to the institution in rendering services to the beneficiary; and (2) either be included, or approved for inclusion, in the U.S. Pharmacopeia, the National Formulary, the U.S. Homeopathic Pharmacopoeia, or New Drugs or Accepted Dental Remedies (except for those unfavorably evaluated), or be approved by the pharmacy and drug therapeutics or equivalent committee of the medical staff of the hospital for use in the hospital.

A. Drugs Included in the Drug Compendia.—Coverage is provided only for those drugs and biologicals included, or approved for inclusion, in the latest official edition or revision of the compendia. The latest official editions are: (1) U.S. Pharmacopeia, 17th Revision, official from September 1, 1965, (2) the National Formulary, 12th Edition, official from September 1, 1965, (3) U.S. Homeopathic Pharmacopoeia, 7th Revised Edition, 1964, (4) New Drugs, 1966, and (5) Accepted Dental Remedies, 1966.

The exclusion from coverage of drugs and biologicals unfavorably evaluated in New Drugs and Accepted Dental Remedies applies to those drugs and biologicals which have been unfavorably evaluated for **all** medicinal uses. If a drug or biological has been unfavorably evaluated for one or more, **but not all**, medicinal uses, the exclusion applies only where the drug has been unfavorably evaluated for the medicinal use to which it is being put.

Drugs and biologicals are considered "approved for inclusion" in a compendium if approved under the procedure established by the professional organization responsible for the revision of the compendium.

B. Approval by Pharmacy and Drug Therapeutics Committee.—A pharmacy and drug therapeutics or equivalent committee is a medical staff committee which confers with the hospital pharmacist in the formulation of policies pertaining to drugs. Drugs and biologicals approved for use in the hospital by such a committee are covered only if the committee

develops and maintains a formulary or list of drugs accepted for use in the hospital. The committee need not function exclusively as a pharmacy and drug therapeutics committee; it may carry on other medical staff functions.

Drugs and biologicals are considered approved for use in the hospital if selected for inclusion in the hospital drug list or formulary under the procedure of the committee established for that purpose. Express approval is required; the fact that a drug or biological has not been specifically determined to be unacceptable for use in the hospital does not constitute approval.

Drugs and biologicals are covered if approved for general use in the hospital, or if approved for use by a particular patient or group of patients. If the pharmacy and drug therapeutics committee gives approval for use of an investigational drug in the hospital, the drug will be covered to the extent that its cost is not met by funds provided for research.

C. Combination Drugs.—Combination drugs are covered if the combination itself or all of the therapeutic ingredients of the combination are included, or approved for inclusion, in any of the designated drug compendia. Any combination drug approved for use in the hospital by the pharmacy and drug therapeutics or equivalent committee is covered.

D. Drugs Specially Ordered for Inpatients.—Coverage is not limited to drugs and biologicals routinely stocked by the hospital; a drug or biological not stocked by the hospital which the hospital obtains for the patient from an outside source, such as a community pharmacy, can also be covered.

Drugs and biologicals not included in the drug list or formulary maintained by the hospital's pharmacy and drug therapeutics committee may be covered if the hospital has a policy which permits such drugs to be furnished to a patient at the special request of a physician. However, in order to be covered, such drugs and biologicals must be included, or approved for inclusion, in one of the designated drug compendia. (In addition, a combination drug, or all of its therapeutic ingredients, would have to be included or approved for inclusion in one of the compendia.)

E. Drugs for Use Outside the Hospital.—Drugs and biologicals furnished by a hospital to an inpatient for use outside the hospital are, in general, not covered as inpatient hospital services. However, if the drug or biological is deemed medically necessary to permit or facilitate the patient's departure from the hospital, and a limited supply is required until he can obtain a continuing supply, the limited supply of the

drug or biological is covered as an inpatient hospital service.

210.4 Supplies, Appliances, and Equipment.—Supplies, appliances, and equipment which are ordinarily furnished by the hospital for the care and treatment of the beneficiary solely during his inpatient stay in the hospital are covered inpatient hospital services.

Under certain circumstances, supplies, appliances, and equipment used during the beneficiary's inpatient stay are covered even though they leave the hospital with the patient when he is discharged. These are circumstances in which it would be unreasonable or impossible from a medical standpoint to limit the patient's use of the item to the periods during which the individual is an inpatient. Examples of items covered under this rule are cardiac valves, cardiac pacemakers, and artificial limbs which are permanently installed in or attached to the patient's body while he is an inpatient of the hospital; and items, such as tracheostomy or drainage tubes, which are temporarily installed in or attached to the patient's body while he is receiving treatment as an inpatient and which are also necessary to permit or facilitate the patient's release from the hospital.

Supplies, appliances, and equipment furnished to an inpatient for use **only** outside the hospital are not, in general, covered as inpatient hospital services. However, a temporary or disposable item which is medically necessary to permit or facilitate the patient's departure from the hospital, and is required until the patient can obtain a continuing supply is covered as an inpatient hospital service.

The reasonable cost of oxygen furnished to hospital inpatients is covered under Part A as an inpatient supply.

210.5 Other Diagnostic or Therapeutic Items or Services.—Other diagnostic or therapeutic items or services ordinarily furnished inpatients by the hospital or by others under arrangements made by the hospital are covered. This category of covered services encompasses items and services not otherwise specifically listed as covered inpatient hospital services. With respect to items that leave the hospital with the patient when he is discharged, such as splints or casts, the rules for determining whether the item is covered are the same as the rules set forth above for supplies, appliances, and equipment.

When a psychologist or physical therapist is a salaried member of the staff of a hospital, his diagnostic or therapeutic services to inpatients of that hospital are covered on a reasonable cost basis in the same

manner as the services of other nonphysician hospital employees. The services of a psychologist or physical therapist who is not a salaried staff member are covered if furnished by the hospital as part of the services it ordinarily furnishes under arrangements which provide for billing to be handled by the hospital.

Diagnostic services furnished under arrangements with laboratories are covered as follows:

A. Diagnostic services furnished to an inpatient by an independent clinical laboratory under arrangements with the hospital are reimbursable under hospital insurance if the specified requirements are met. Where State or applicable local law provides for licensing of independent clinical laboratories, diagnostic services furnished by such a laboratory are covered only if the laboratory is either licensed under such law or is approved as meeting the requirements for licensing by the State or local agency responsible for licensing laboratories. Such laboratories must also meet the health and safety requirements prescribed by the Secretary of Health, Education, and Welfare. See "Conditions for Coverage of Services of Independent Laboratories."

An independent laboratory is one which is independent both of the attending or consulting physician's office and of a hospital which is participating in the program as a provider of services. A laboratory which is part of a nonparticipating hospital is considered to be an independent laboratory. The laboratory which a physician or group of physicians maintains for performing diagnostic tests in connection with his or their own practice would not be considered an "independent laboratory." An out-of-hospital laboratory is ordinarily presumed to be independent unless there is written evidence establishing that it is operated by or under the supervision of a participating hospital or its organized medical staff. A laboratory operated on the hospital's premises is ordinarily presumed to be operated by or under the supervision of the hospital or its organized medical staff, and therefore not an independent laboratory.

A clinical laboratory is a laboratory where microbiological, serological, chemical, hemotological, biophysical, cytological, immuno-hematological or pathological examinations are performed on materials derived from the human body, to provide information for the diagnosis, prevention or treatment of a disease or assessment of a medical condition.

B. Diagnostic services furnished a hospital inpatient under arrangements with the laboratory of another participating hospital are reimbursable

on a cost basis under Part A to the hospital obtaining the services.

NOTE: Where a hospital obtains diagnostic laboratory services for inpatients under arrangements described in § 210.5A or § 210.5B, the cost to the hospital obtaining the services would be the reasonable charge for the laboratory's service.

210.6 Services of Interns or Residents-in-Training.—Hospital insurance covers the reasonable cost of the services of interns or residents-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association.

In the case of services of interns or residents-in-training in the field of dentistry in a hospital or osteopathic hospital, the teaching program must have the approval of the Council on Dental Education of the American Dental Association.

See § 240.1 for coverage of services of hospital interns and residents under medical insurance.

210.7 Inpatient Services in Connection With Dental Services.—When a patient is hospitalized for a dental procedure and the dentist's service is covered under Part B, the inpatient hospital services furnished during the stay are covered under Part A. For example, both the professional services of the dentist and the inpatient hospital expenses are covered when the dentist reduces a jaw fracture of an individual who is an inpatient of a participating hospital. See also §§ 245, 260.12, and 274.

Where a patient is hospitalized **solely** for non-covered dental treatment (§ 260.12) neither the professional services of the dentist nor the inpatient hospital services are covered.

If a patient is hospitalized for a noncovered dental procedure, but the hospitalization is required to assure proper medical management, control, or treatment of a nondental impairment, the inpatient hospital services are covered. An example is a patient with a history of repeated heart attacks who must have all of his teeth extracted. Include an explanation when the bill is submitted. In these cases all ancillary services **furnished by the hospital**, such as x-rays, administration of anesthesia, use of the operating room, etc., are covered. See § 274 for required certification.

Regardless of whether the inpatient hospital services are covered, the medical services of physicians furnished in connection with noncovered dental services,

are not covered. Thus, the services of an anesthesiologist, radiologist, or pathologist whose services are performed in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth are not covered.

Duration of Covered Inpatient Services

215. SPELL OF ILLNESS DEFINED

A spell of illness is a period of consecutive days that **begins** with the first day (not included in a previous spell of illness) on which a patient is furnished inpatient hospital or extended care services by a qualified provider in a month for which the patient is entitled to hospital insurance benefits. A qualified provider is a hospital (including a psychiatric or tuberculosis hospital) or extended care facility that has been certified as meeting all the requirements of the definition of such an institution. A hospital which meets the requirements in § 202 is a qualified hospital for purposes of beginning a spell of illness when it furnishes the patient covered inpatient emergency services. **Thus, generally, the spell of illness begins when covered inpatient services are initially furnished to an entitled individual.**

If a person is in a nonqualified institution on the first day of his entitlement under Part A and is subsequently transferred to a qualified hospital (general, psychiatric, or tuberculosis), his spell of illness begins on admission to the qualified hospital.

Admission to a qualified extended care facility will begin a spell of illness even though payment for the services cannot be made because the prior hospitalization or transfer requirement has not been met (see § 110.2).

The spell of illness **ends** with the close of a period of 60 consecutive days during which the patient was neither an inpatient of a hospital nor an inpatient of an extended care facility. To determine the 60-consecutive-day period, begin counting with the day on which the individual was discharged. *It is important to note that for purposes of continuing a spell of illness the hospital or extended care facility in which the stay occurs need not meet all of the requirements that are necessary for starting a spell of illness.*

Inpatient services will prolong the beneficiary's spell of illness if the **hospital** meets the initial requirement of the definitions in §§ 200, 203, or 204. That is, it is primarily engaged in providing, by or under the supervision of physician(s), to inpatients (1) diagnostic and therapeutic services for medical diagnosis,

treatment, and care of injured, disabled, or sick persons, or rehabilitation services for injured, disabled, or sick persons; **or**, (2) psychiatric services for the diagnosis and treatment of mentally ill persons; **or** (3) medical services for the diagnosis and treatment of tuberculosis.

Similarly, inpatient services in an **extended care facility** will prolong a beneficiary's spell of illness if the facility (including one primarily for the care and treatment of mental diseases or tuberculosis) meets at least the requirement that it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for injured, disabled, or sick persons.

An individual may be discharged from and readmitted to a hospital or extended care facility several times during a spell of illness and still be in the same spell if 60 days have not elapsed between discharge and readmission. The stay need not be for related physical or mental conditions. As long as a person continues to be entitled to hospital insurance, there is no limit to the number of spells of illness he may have.

Example 1: X was born August 9, 1902. On July 28, 1967, X entered a participating general hospital. After he had been in the hospital for 2 weeks, X was discharged on August 11, 1967. On his doctor's orders X entered a participating nursing home on August 15, 1967, and remained there until his discharge on October 27, 1967. He had no further inpatient stays in 1967.

X's spell of illness began on August 1, 1967, the first day of the month he attained age 65 and was entitled to hospital insurance. The spell of illness ended December 25, 1967, the end of the 60-day period beginning with the date of his last discharge.

Example 2: Y, over age 65, entered a participating general hospital on July 28, 1968, for treatment of a heart condition. He was discharged on August 11, 1968. On August 20, 1968, Y entered a **nonparticipating nursing home**, which provided primarily skilled nursing care and related services. Y remained in this facility until his discharge on October 27, 1968. On December 25, 1968, Y was again admitted to a participating hospital because of injuries suffered in an accident. He was discharged on January 13, 1969, and had no further inpatient stays in 1969.

Y's spell of illness began on July 28, 1968. His stay in the nursing home began less than 60 days after his hospital stay and the spell was continued even though the stay was not covered. The subsequent hos-

pital stay began less than 60 days after the nursing home stay and continued the spell of illness, although the condition treated was unrelated to his prior stays. The spell ended on March 13, 1969, the end of the 60-day period beginning with the day of last discharge.

216. INPATIENT HOSPITAL BENEFIT DAYS

A patient having hospital insurance coverage is entitled to have payment made on his behalf for up to **90 days** of covered inpatient hospital services in each spell of illness. (For coinsurance provision, see § 225.)

216.1 Inpatient Day Defined.—The number of days of care charged to a beneficiary for inpatient hospital services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is to be used in reporting days of care for beneficiaries, even if the hospital uses a different definition of day for statistical or other purposes.

A part of a day, including the day of admission, counts as a full day. However, the day of discharge, or a day on which a patient begins a leave of absence, is not counted as a day. (Charges for ancillary services on the day of discharge are covered under the reimbursement formula.) If admission and discharge occur on the same day, the day is considered a day of admission and counts as one inpatient day. (For billing when a patient is transferred to another hospital before midnight of the day of admission, see § 402.1, Item 19, and § 410.1 Item 20.)

216.2 Late Discharge.—When a patient chooses to continue to occupy his hospital accommodations beyond the checkout time for personal reasons, the hospital may charge the beneficiary for his continued stay. Such a stay beyond the checkout time, for the comfort or convenience of the patient, is not covered under the program and the hospital's agreement to participate in the program does not preclude it from charging the patient. However, it is expected that hospitals will not impose late charges on a beneficiary unless he has been given reasonable notice (for example, 24 hours) of his impending discharge.

Where the patient's medical condition is the cause of the stay past the checkout time (e.g., the patient needs further services, is bedridden and awaiting transportation to his home or to an extended care facility, or dies in the hospital), the stay beyond the discharge hour is covered under the program and the hospital may not charge the patient.

216.3 Leaves of Absence.—The day on which the patient began a leave of absence is treated as a day of discharge and is not counted as an inpatient day unless he returns to the hospital by midnight of the same day. The day the patient returns to the hospital from a leave of absence is treated as a day of admission and is counted as an inpatient day if he is present at midnight of that day.

216.4 Discharge on First Day of Entitlement or Participation.—In the following special situations program payment is not made for accommodations on the day of discharge, but is made for ancillary services provided on that day: (a) Where a patient is admitted prior to the first day of his entitlement and is discharged from a participating hospital on the first day of his entitlement; and (b) where a patient in a non-covered stay in a nonparticipating hospital is discharged on the first day the hospital becomes a participating hospital. For a late discharge on such a day, the rules in § 216.2 will be followed. Although in these situations a day of utilization is not counted, a spell of illness begins and any charges for covered services are applied against the deductible.

217. INPATIENT TUBERCULOSIS AND PSYCHIATRIC RESTRICTION

If an individual is in a participating tuberculosis or psychiatric hospital on the first day of his entitlement to hospital insurance, the number of inpatient benefit days in his first spell of illness is subject to reduction. The days (not necessarily consecutive) on which he was an inpatient of a psychiatric or tuberculosis hospital in the 90-day period immediately before the first day of entitlement, must be subtracted from the 90 days of inpatient hospital services for which he would otherwise be eligible in his first spell of illness. Days spent in a **general hospital** for diagnosis or treatment of tuberculosis or a psychiatric condition prior to entitlement will not reduce the patient's 90 inpatient benefit days in his initial spell of illness.

When this reduction applies, it applies to all inpatient hospital services in the initial spell of illness whether received in a tuberculosis or psychiatric hospital, or in a general hospital. For example, if a patient in a psychiatric hospital has no benefit days remaining because of this reduction, a subsequent stay in a general hospital in his initial spell of illness will not be covered.

See § 225 for the effect of this provision on the coinsurance provision.

217.1 Patient Status on Day of Entitlement.—A patient who is in a participating tuberculosis or psychiatric hospital on the first day of his entitlement is

subject to the restriction. The restriction applies to patients admitted to or discharged from such a hospital on their first day of entitlement, or who begin or end a leave of absence on that day. Where only a distinct part of an institution is participating as a tuberculosis or psychiatric hospital, the provision applies only to patients who, on their first day of entitlement, are inpatients of that part.

The provision does not apply to persons who are receiving inpatient diagnostic or therapeutic services for tuberculosis or a psychiatric condition in a general hospital on their first day of entitlement. It also does not apply to patients who, on that day, are inpatients of a tuberculosis or psychiatric institution's medical-surgical facility, if that facility is participating as a general hospital (§ 205.2).

217.2 Institution's Status in Determining Days Deducted.—The status of a tuberculosis or psychiatric hospital (or a distinct part of such a hospital) as of the individual's first day of entitlement is controlling in determining whether days spent there during the preceding 90 days are to be deducted. Thus, deductions would be made for days spent in a hospital (or distinct part) which was participating as of the individual's first day of entitlement even though it was not participating during all or part of the preceding 90 days. However, where an institution is not participating as of the individual's first day of entitlement, deductions would not be made for days spent in that institution during the preceding 90 days, even though the institution is later certified for participation as a tuberculosis or psychiatric hospital.

Where a participating tuberculosis or psychiatric hospital is a distinct part of an institution, deductions are made only for days spent in the wards, floors, wings, etc., included in the participating distinct part as of the individual's first day of entitlement, even though it was not participating during all or part of the preceding 90 days. Deductions are not made for days spent in a part of the institution not included in the participating distinct part as of the individual's first day of entitlement, e.g., days spent in a custodial section of the institution or days spent in a general medical-surgical facility participating as a general hospital.

217.3 Days of Admission, Discharge, and Leave.—In determining the number of days to be deducted, include days of admission and days on which the patient returned from leave of absence. Do not count days of discharge, days on which the patient began a leave of absence, or days of leave during all of which the individual was absent from the hospital.

218. INPATIENT PSYCHIATRIC HOSPITAL SERVICES—LIFETIME LIMITATION

Payment may not be made for more than a total of 190 days of inpatient psychiatric hospital services during the patient's lifetime. **The limitation applies only to services furnished in a psychiatric hospital.** The period spent in a psychiatric hospital prior to entitlement does not count against the patient's lifetime limitation, even though preentitlement days may have been counted against the 90 days of eligibility in the first spell of illness.

219. INPATIENT SERVICES DAYS COUNTING TOWARD MAXIMUMS

Inpatient hospital (including psychiatric and tuberculosis hospital) services count toward the maximum number of benefit days payable per spell of illness only if—

A. payment for the services is made, or

B. payment for the services would be made if a request for payment were properly filed and if a physician certified that the services were necessary. Where payment cannot be made because of the inpatient deductible or coinsurance requirement, the inpatient days used in satisfying these requirements nevertheless count toward the beneficiary's maximum inpatient days.

Similiary, inpatient psychiatric hospital services count toward the 190-day lifetime limitation on inpatient psychiatric hospital services only if these conditions are met.

Inpatient Deductibles and Coinsurance

220. DEDUCTIBLE

The patient is responsible for a deductible amount of \$40 for inpatient hospital services in each spell of illness. This amount is subject to change, but not before 1969. Each year beginning in 1968, the Secretary of Health, Education, and Welfare will determine the amount of the deductible for the following year.

The deductible is satisfied only by charges for **covered** services. Expenses for covered services count toward the deductible on an incurred rather than paid basis. Expenses incurred in one spell of illness cannot be applied toward meeting the deductible in a later spell of illness. Expenses incurred in meeting the whole blood deductible do not count toward the inpatient hospital deductible.

A reduction in benefit days resulting from confinement in a tuberculosis or psychiatric hospital on and immediately preceding the date of entitlement (see

§§ 217 ff) does not affect the amount of the deductible for which the patient is responsible. The deductible amount remains at \$40.

If a patient has not yet met the inpatient deductible and both the customary and actual charges for the inpatient stay are less than \$40, the greater of the two will be applied toward the deductible. (See § 210.1D for a definition of customary charges.) There may be some interim reimbursement to the hospital even though the patient has not met the deductible.

Example: The total charge to the patient is \$20. Customary charge for the services \$25. The intermediary has established a reasonable cost per diem rate for the hospital of \$39.

The amount creditable to the patient's deductible, using the customary charge, is \$25. The hospital shows charges of \$25 on its bill to the program. Although the patient has met only \$25 of his \$40 deductible, the hospital receives an interim payment of \$14 (interim per diem less customary charge).

222. WHOLE BLOOD DEDUCTIBLE

A. Whole Blood Defined.—For purposes of the whole blood deductible, whole blood is human blood from which none of the liquid or cellular components have been removed. Components of blood such as packed cells, plasma, gamma globulin, etc., are not subject to the whole blood deductible. These components of whole blood are covered biologicals. (See § 210.3 for coverage of biologicals.)

B. Deductible.—Generally, in each spell of illness no payment for the first 3 pints of whole blood may be made under the program. (See C below for the exception for such blood furnished by an independent blood bank.) After the 3-pint deductible has been satisfied, the program pays the hospital's blood costs whether the blood comes from the hospital's own blood bank or is obtained from an independent blood bank.

The whole blood deductible applies only to the first 3 pints of blood furnished in any spell of illness, even though more than one provider furnishes blood. This deductible is in addition to any other applicable deductible and coinsurance amounts for which the patient is responsible.

Example: In the same spell of illness, an individual was an inpatient in hospital X and then in hospital Y. He received 2 pints of whole blood in hospital X and 4 pints in hospital Y. The whole blood deductible applies to the 2 pints furnished by hospital X and 1 of the pints furnished by hospital Y.

The patient may be charged for any of the first 3 pints of whole blood which is not replaced. The hospital can-

not charge the patient for any of the first 3 pints of blood which is replaced on a pint-for-pint basis. In billing the program, the hospital shows the **charge** for **all** unreplaced pints of blood. When program reimbursement is computed, the **cost** of **all** unreplaced blood will be reduced by the amount the hospital charged for deductible pints that were not replaced. Thus, when the charge to the patient for any of the first 3 pints not replaced exceeds the cost of the blood, program payment to the hospital will be reduced by the difference.

Example: A hospital furnished 100 pints of blood which were not replaced and for which the charge was \$15 per pint. 80 pints were covered pints and 20 pints were deductible pints for which beneficiaries were charged. On audit the cost of blood was determined to be \$10 per pint. The program reimbursement to the hospital is \$700 (the cost of all unreplaced blood, \$1,000, less the charges to beneficiaries for deductible pints not replaced, \$300).

The deductible involves only the cost of the blood itself. Costs incurred by the hospital in **administering, storing, and processing** whole blood are not part of the whole blood deductible. These costs are covered by the hospital insurance program whether or not the blood is replaced.

Example: A patient during his first stay in a spell of illness receives 5 pints of whole blood from the hospital's own blood bank. Relatives donate 3 pints on the patient's behalf. The patient may not be charged for whole blood since he replaced the first 3 pints he received. The cost of the 2 pints not replaced and the hospital's cost in administering all of the blood to the patient, in taking the blood from the donors, and in processing the blood are reimbursable under Part A.

Some hospitals customarily require replacement of blood in an amount greater than that furnished the patient. For example, a nonbeneficiary patient, furnished 3 pints of blood, is subject to a charge unless he arranges to replace 4 pints. Such a hospital is free to persuade a beneficiary to arrange for donation of more blood than was furnished to him. However, the hospital may not charge a beneficiary who fails to comply with such a request if he has replaced on a pint-for-pint basis each of the first 3 pints he received.

Where more blood is donated on behalf of a patient than is required for full replacement on a pint-for-pint basis, the value of the excess blood is not deducted from the amount payable to the hospital under Part A. However, such donations would tend to reduce the cost of blood to the hospital.

C. Provisions Applicable to Blood from Independent Blood Banks.—Where (1) a provider has furnished any of the first 3 pints of blood received by an individual under Part A during a spell of illness, and (2) this blood was obtained by the provider from an independent blood bank, and (3) the blood was replaced at least pint-for-pint on behalf of the individual, the program will pay the hospital its net cost for such blood. The hospital's net cost for such blood is the net charge of the blood bank after credit for replacement.

Payment by the program to the hospital for any of the deductible pints which the patient has replaced on a pint-for-pint basis may not exceed two-thirds of the amount the blood bank would have charged for those pints had they not been replaced. The program will not pay any of the blood bank's charge to the hospital for any of the first 3 pints not replaced.

If the hospital's charge to the patient for any of the first 3 pints not replaced exceeds the blood bank's charge to the hospital for the blood, program payment to the hospital will be reduced by the difference.

Example 1: A hospital obtains its whole blood from an independent blood bank which charges \$20 per pint with a rebate of \$10 for each pint replaced. Three pints of blood are furnished by the hospital to a patient who has met no part of the whole blood deductible. His relatives donate 2 pints of blood. The hospital may charge the patient \$20 for the pint of blood not replaced. The hospital will bill the program for \$20 as its net cost for the 2 pints replaced.

Example 2: Same facts as Example 1 except that the patient's relatives donate 4 pints of blood. The patient's deductible is satisfied in this case and he is not responsible for any whole blood charges. The hospital's net cost for the blood furnished the patient is again \$20. (Blood bank charges for 3 pints—\$60, less bank's rebate for 4 pints donated—\$40.)

D. Volunteer Blood Banks.—When blood is furnished by a volunteer blood bank at no charge to the hospital, it will be considered as replaced blood for purposes of meeting the whole blood deductible.

If the blood bank makes a service charge which applies whether or not the blood is replaced, this charge will be considered a covered hospital cost. However, where the service charge is made only for unreplaced blood, the charge applicable to deductible pints not replaced will be the responsibility of the patient as a charge for blood.

225. COINSURANCE

The patient is responsible for a coinsurance amount, initially \$10 (one-fourth of the inpatient hospital deductible), for each day after the 60th day and through the 90th day of inpatient hospital services furnished during a spell of illness.

Where the actual charge to the patient is less than \$10 per day, the coinsurance is the actual charge per day. In billing both the patient and the program, the coinsurance amount is the same.

When preentitlement days of hospitalization in a tuberculosis or psychiatric hospital are counted toward the 90-day limit on inpatient hospital days in the initial spell of illness (see § 217), these preentitlement days are charged first against coinsurance days.

Example: An individual was an inpatient of a tuberculosis hospital on 15 days (counting days of admission but not days of discharge) of the 90 days prior to October 1, 1966, the date he became entitled to hospital insurance. He was an inpatient of this hospital on October 1, 1966, and continued to be hospitalized. Although he was not entitled to benefits prior to October 1, the 15 days of hospitalization prior to entitlement count toward the 90-day limit on inpatient services for the spell of illness beginning October 1, 1966. Following the rule stated above, the 30 coinsurance days available were reduced by 15, while, in this case, full benefit days were unaffected. His responsibility for the \$10 per day coinsurance began November 30, 1966, which is the 61st day in the spell of illness begun on October 1, 1966. He then had only 15 days remaining in that spell of illness for which payment could be made for inpatient hospital services, and to which the coinsurance amount would apply.

Outpatient Hospital Services

230. OUTPATIENT HOSPITAL SERVICES—GENERAL

A hospital outpatient is a person who has not been admitted by the hospital as an inpatient and who is not lodged in the hospital while receiving outpatient hospital services. (For definition of "inpatient," see § 210.)

Where a hospital uses the category "day patient," i.e., an individual who receives hospital services during the day and is not expected to be lodged in the hospital at midnight, the individual is classified as an outpatient. For billing of outpatient services furnished before admission as an inpatient see § 400.

Hospitals provide two distinct types of services to outpatients, namely (1) services that are diagnostic in

nature, and (2) other services which aid the physician in the treatment of his patient. The outpatient hospital diagnostic services are covered under Part A. All other hospital services provided on an outpatient basis which are incident to physicians' services rendered to outpatients are covered under Part B. The hospital is reimbursed for both types of services on a reasonable cost basis.

230.1 Rules for Distinguishing Outpatient Hospital Services.—Outpatient hospital services covered under Parts A and B must be separately identified. However, since a patient may receive services covered under both Parts A and B during a single visit to the outpatient department, questions may arise about how to classify a particular service.

If the physician designates certain services as being for diagnostic purposes and separates them from services that are not diagnostic, the hospital may accept these designations. Normally, however, the physician does not separate the services and need not be asked to do so. Where such a separation of services is not made, hospital and intermediary personnel should use the following rules in deciding how to allocate services to Parts A and B:

A. Any diagnostic laboratory test or other identifiable diagnostic test furnished by the hospital (or under arrangements as described in § 232) and normally identified as such for billing purposes, will be billed to Part A. **Any services which can be billed to Part A under this rule must be so billed.** (Outpatient diagnostic services are described in §§ 232 ff. and coverage under Part A and Part B in §§ 236 and 240.2.)

B. All other clinic services and emergency services (even though they may contain some diagnostic implications but are not normally identified as diagnostic services) will be billed to Part B. (Other outpatient hospital services are described in § 234, and in greater detail in §§ 240 ff.)

232. OUTPATIENT DIAGNOSTIC SERVICES

A service may be regarded as "diagnostic" if it is an examination or procedure to which the patient is subjected, or which is performed on materials derived from the patient, to obtain information to aid in the assessment of a medical condition or the identification of a disease. Among these examinations and tests are diagnostic laboratory services such as hematology and chemistry, diagnostic x-rays, isotope studies, EKG's, pulmonary function studies, thyroid function tests, psychological tests and other tests given to determine the nature and severity of an ailment or injury.

When furnished by the hospital, diagnostic services, including the services of nurses, psychologists, physical therapists, and technicians, and the use of supplies and equipment are covered under Part A. When a hospital sends hospital personnel and hospital equipment to a patient's home to furnish a diagnostic service, the service is covered under Part A as if the patient had received the service in the hospital outpatient department.

Hospital personnel may provide diagnostic services outside the hospital premises without the direct personal supervision of a physician. For example, if a hospital laboratory technician is sent by the hospital to a patient's home to obtain a blood sample for testing in the hospital's laboratory, the technician's services would be a covered hospital service under Part A regardless of the fact that a physician was not with the technician. (See § 240.2.A for coverage under Part B of therapeutic services furnished outside the hospital premises.)

Where the hospital makes arrangements with others for diagnostic services, such services are covered under Part A only if they are provided (1) in the hospital (e.g., through lease agreement), or (2) by another facility operated by or under the supervision of the hospital or its medical staff. Where the hospital bills for diagnostic services provided by qualified facilities which do not meet these requirements, payment can be made to the hospital under Part B subject to the conditions in § 232.2 and § 232.3 below.

232.1 Types of "Arrangements."—Hospitals currently maintain a variety of relationships with other laboratories for the purpose of supplementing their own facilities in providing diagnostic laboratory services to their patients. Some hospitals rely routinely on independent laboratories; some obtain their services only occasionally.

232.2 Diagnostic Services Obtained from "Independent" Laboratories.—Where a hospital obtains laboratory services for its outpatients under arrangements with an independent laboratory, reimbursement will be made to the hospital on a cost basis under the provisions of Part B. The laboratory must meet the requirements in § 210.5A.

232.3 Diagnostic Services Obtained Under Arrangements With Another Hospital's Laboratory.—Diagnostic laboratory services obtained for a hospital outpatient under arrangements with the laboratory of another participating hospital are reimbursable to the first hospital on a cost basis under Part B; i.e., the services were furnished in a facility not op-

erated by or under the supervision of the first hospital or its organized medical staff.

NOTE: Where a hospital obtains diagnostic laboratory services for outpatients under arrangements described in § 232.2 or § 232.3, the "cost" to the hospital which obtains the services is the reasonable charge by the laboratory.

234. OTHER OUTPATIENT HOSPITAL SERVICES WHICH AID THE PHYSICIAN

The services, other than diagnostic services, which hospitals provide on an outpatient basis generally relate to the services that aid the physician in the treatment of his patients. Such services, which include clinic services and emergency services, are covered under Part B.

Special items and services which are covered when furnished during a visit to the clinic include, for example, the services of nurses, psychologists, and technicians; use of emergency room; medical supplies such as gauze, dressings, oxygen, ointments, splints, braces, and other supplies used by the physician in treating the patient; drugs and biologicals which cannot be self-administered; radiology treatments; and special therapy treatments. See also § 240.1.

Outpatient Hospital Diagnostic Services Under Hospital Insurance

236. COVERED OUTPATIENT DIAGNOSTIC SERVICES

A patient with hospital insurance coverage is entitled to have payment made for outpatient hospital diagnostic services. (Outpatient diagnostic services are on a 20-day diagnostic study basis and are not related to a spell of illness.) These services include:

A. **Diagnostic tests and related services** to the extent they would be covered if performed on an inpatient basis;

B. **Drugs and biologicals** necessary for diagnostic study (see § 210.3 for definition of drugs and biologicals);

C. **The services** rendered in connection with a diagnostic study **by an intern or resident-in-training** in an approved teaching program (if not under an approved teaching programs, see § 240.1C);

D. **Other services and supplies** if customarily furnished to outpatients for purposes of diagnostic studies.

If the beneficiary has coverage only under the medical insurance plan, payment for diagnostic services can be made under Part B. (See § 240.2 for Part B diagnostic services.)

236.1 Outpatient Hospital Diagnostic Study Period.—A diagnostic study is a period of **20 consecutive days beginning** with the first day on which the patient is furnished outpatient hospital diagnostic services. The diagnostic services furnished during a single study must be furnished by (or under arrangements made by) the **same hospital**.

A subsequent study may not begin in (or under arrangements made by) the same hospital until the prior study has been completed. However, two or more studies may be conducted at the same time in different hospitals.

The study ends after 20 days regardless of the number of days on which diagnostic services were actually furnished. Diagnostic services which continue beyond 20 days are considered to be in a new study period and must be separately billed.

236.2 Deductible for Outpatient Hospital Diagnostic Services.—The deductible for outpatient hospital diagnostic services for each 20-day diagnostic study period is \$20 (i.e., one-half of the inpatient hospital deductible). This deductible amount counts as an incurred Part B expense for individuals having medical insurance coverage. (See §§ 245–248 for explanation of supplementary medical insurance incurred expenses, deductible, coinsurance, and relation to the Part A outpatient diagnostic deductible.)

236.3 Coinsurance for Outpatient Hospital Diagnostic Services.—After satisfying the deductible, the patient is responsible for a coinsurance amount equal to 20 percent of the reasonable or the customary charges, whichever is less, for the diagnostic services rendered during the diagnostic study.

Hospital Services Covered Under Supplementary Medical Insurance

240. COVERAGE OF HOSPITAL SERVICES UNDER SUPPLEMENTARY MEDICAL INSURANCE—GENERAL

The supplementary medical insurance program provides payment for physicians' services and certain other specified health services and supplies **unless** such services or supplies would otherwise constitute inpatient hospital services, extended care services, or home health services. For example, Part B payment **may not** be made to a hospital for diagnostic x-rays, laboratory services, x-ray therapy, or other services furnished to inpatients (see § 240.1A for an exception for interns and residents).

This is true even when no Part A benefit is payable, i.e., **the inpatient has exhausted his 90 days of coverage in a spell of illness**; the services do not meet the special requirements for coverage in a psychiatric or tuberculosis hospital; **or** the hospital is not participating.

The only medical services and supplies furnished by a hospital for which payment may be made under Part B are those discussed in §§ 240.1 to 240.4.

240.1 Services of Interns and Residents.—Services performed by interns and residents—including physicians employed by a hospital who are authorized to practice only in a hospital setting—are reimbursable to the hospital on a reasonable cost basis even though the intern or resident is also a licensed physician. Services of interns and residents covered under Part B include:

A. The medical and surgical services performed for hospital inpatients by interns and residents who are not under approved teaching programs;

B. The diagnostic medical and surgical services performed in hospital outpatient departments by interns and residents not under an approved teaching program;

C. The medical and surgical services (other than diagnostic services) performed in hospital outpatient departments by interns and residents regardless of whether they are under an approved teaching program.

See § 210.6 (inpatient hospital) and § 236C (outpatient hospital diagnostic) for description of coverage under Part A of other services which interns and residents-in-training perform.

240.2 Hospital Services and Supplies Incident to Physicians' Services.—Payment may be made under the supplementary medical insurance plan for hospital services and supplies (including drugs and biologicals which cannot be self-administered) which are incident to physicians' services rendered to outpatients (see § 245 for definition of physician).

A. Hospital Services Incident to Physicians' Services.—All services provided by the hospital in connection with the physician's diagnosis or treatment of outpatients are covered under Part B as incident to physicians' services (unless otherwise specifically excluded). This includes the use of the hospital's facilities, and the services of nurses, nonphysician anesthetists, psychologists, technicians, therapists (including physical therapists), and other aides. There is no requirement that the physician who orders the hospital services be directly connected with the department which provides the services. When such hospital services are diagnostic, they are covered under Part A

(see § 232); all other services are covered under Part B.

If hospital personnel provide therapeutic services outside the hospital premises, the services are covered under Part B as incident to physicians' services only if there is direct personal supervision by a physician. For example, if a hospital therapist goes to a patient's home to give treatment and no physician accompanies him, the therapist's services would not be covered. (Such a service would be covered as a home health service if provided as part of a home health plan under arrangements with a home health agency.)

See § 232 for coverage under Part A of outpatient diagnostic services furnished outside the hospital.

Generally, the only services provided in the outpatient department of a hospital which are not covered under Part B as incident to physicians' services (aside from diagnostic services covered under Part A) are those which do not require participation by hospital personnel acting under specific order by a physician. For example, a hospital may make certain equipment, such as an intermittent positive pressure breathing machine or exercise equipment, available to the patient who is able to use it without assistance or instruction.

B. Hospital Supplies Incident to Physicians' Services.—All supplies provided by the hospital which are necessary and incident to physicians' services rendered to hospital outpatients are covered under Part B, e.g., oxygen, surgical supplies, dressings, and splints, casts, and other devices used for reduction of fractures and dislocations. The following are some additional examples of hospital supplies which are incident to physicians' services:

1. **Drugs and biologicals** of the type which cannot be self-administered are covered under Part B when furnished to outpatients as incident to physicians' services. Generally, they are limited to those administered by injection, including those required on a continuing basis, such as for pernicious anemia or arthritis. However, if the injection is of the type commonly self-administered, such as insulin injections, the drug or biological is excluded unless administered to the patient in an emergency situation. (For definitions of drugs and biologicals and combination drugs, see § 210.3.)

Whole blood administered to outpatients is covered under Part B as a biological which cannot be self-administered. Reimbursement is not subject to the whole blood deductible (see § 222).

Payment may not be made under either Part A or Part B for immunizations, i.e., vaccination or inoculation against diseases such as smallpox, polio, diphtheria,

etc. "Immunization" for this purpose, however, does not include a vaccination or inoculation related to the treatment of a particular injury or direct exposure, e.g., antirabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin. When furnished under these circumstances to a hospital outpatient as an incident to a physician's service, the vaccination or inoculation is covered under Part B.

2. Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) and replacements or repairs for such devices are covered. For example, dialysis equipment used in the treatment of renal failure is covered under Part B as a prosthetic device which replaces the function of a kidney. The term "internal body organ" includes the lens of an eye and all or part of an ear or nose. Prostheses replacing the lens of an eye include postsurgical lenses customarily used during convalescence from eye surgery in which the lens of the eye was removed. In addition, permanent lenses required by an individual lacking the organic lens of the eye, whether by surgical removal or congenital absence, are also covered.

3. Leg, arm, back, and neck braces, trusses, and artificial legs, arms and eyes.—These appliances are covered under Part B when furnished incident to physicians' services or on a physician's order. A brace includes rigid and semirigid devices which are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. Back braces include, but are not limited to, special corsets, sacroiliac, sacrolumbar, dorsolumbar corsets and belts. A terminal device (e.g., hand or hook) is covered when an artificial arm is required by the patient.

Purchase of the initial artificial limb or other appliance, or replacement of it when worn out or unrepairable is covered. The replacement of usable appliances or artificial limbs required because of a change in the patient's physical condition is also covered when supplied on a physician's order. Repairs to and adjustments of such appliances are also covered even when the appliance had been in use before the user enrolled in the supplementary medical insurance program.

240.3 Use of Durable Medical Equipment.—Durable medical equipment is equipment which can withstand repeated use and which generally does not have a value to the patient in the absence of an illness or injury. It includes such items as iron lungs, oxygen tents, oxygen regulators, intermittent positive pressure

breathing machines, hospital beds, wheelchairs, and other ambulation devices such as crutches and walkers. It must be for use in the patient's home or in a place used as his home.

In the rare situation where hospitals may furnish durable medical equipment to a beneficiary for use in his home, the use of the equipment would be an allowable hospital cost, e.g., depreciation, administrative costs involved, etc.

Reimbursement cannot be made to a beneficiary for the purchase of durable medical equipment.

When oxygen is essential for the effective use of the hospital's durable medical equipment in the patient's home, the oxygen and its container are covered. Oxygen used with equipment owned by the beneficiary is not covered. Oxygen and its container used independently of durable medical equipment is covered only as a medical supply, and therefore, only when furnished incident to a physician's professional service. Medications used with durable medical equipment are not covered.

240.4 Ambulance Service.—Ambulance service is covered only under Part B. The cost of oxygen and its administration furnished in connection with and as part of the ambulance service is also covered. (See § 280 for the required certification for ambulance service.)

An ambulance is a specially designed or equipped automobile or other vehicle (in some areas of the United States this might be a boat or plane) for transporting the sick or injured. It must have customary patient care equipment including a stretcher, clean linens, first aid supplies, oxygen equipment, and any safety and lifesaving equipment required by State or local authorities.

Personnel whose duties involve the care or handling of the patient while providing ambulance service must have adequate training in the application of first aid, i.e., training which is at least equivalent to the training provided by the standard and advanced Red Cross first aid courses. The driver does not have to meet the first aid training requirement if there is at least one other person assigned to the ambulance who has had the required training. Training "equivalent" to the standard and advanced Red Cross first aid training courses includes ambulance service training and experience acquired in military service, successful completion by the individual of a comparable first aid course furnished by or under the sponsorship of State or local authorities, an educational institution, a fire department, a hospital, a professional organization, or other

such qualified organization. On-the-job training involving the administration of first aid under the supervision of or in conjunction with trained first aid personnel for a period of time sufficient to assure the trainee's proficiency in handling the wide range of patient care services that may have to be performed by a qualified attendant can also be considered as "equivalent training."

A. For coverage of ambulance services each of the following three conditions must be met:

1. The vehicle used to provide the ambulance service and the ambulance personnel whose duties involve care of the patient meet the requirements specified above.

2. Ambulance service is covered only where the use of any other method of transportation is medically contraindicated by the patient's condition. (In any case in which some means of transportation other than an ambulance could be used without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance service.)

3. The patient must have been transported to the nearest hospital with appropriate facilities or to one in the same locality, **and under similar restrictions**, from one hospital to another, or to an extended care facility. The patient may, likewise, be transported from one of these institutions to his home (or place of residence) if his home is within the locality of the institution.

The requirement that a patient be transported to the **nearest hospital with appropriate facilities** or to one in the **same locality** as that hospital (and under similar restrictions from one hospital to another, to the patient's home, or to an extended care facility) is intended to provide coverage of essential ambulance service, without imposing an arbitrary "mileage" limitation. It is not contemplated, however, that payment would be made for ambulance services that involve transporting the patient beyond the locality even if the patient is transported to a participating hospital or extended care facility. The term **locality**, with respect to ambulance service, means the service area in the geographic territory surrounding the institution from which individuals normally come or are expected to come for medical services.

The term **appropriate facilities** means that the institution has available the services, supplies, and staff necessary to provide the medical care called for by the patient's injury or illness. The fact that a more distant institution is better equipped, either

qualitatively or quantitatively, to care for the patient does not warrant a finding that a closer institution does not have "appropriate facilities." However, a patient need not necessarily be taken to the nearest hospital or facility with appropriate facilities; he can be taken to another hospital or facility in the same locality.

B. Transportation by ambulance to a hospital to obtain home health services not available to the individual in his home is covered as a Part B service only if the three conditions in A above are met. Such transportation is not covered as a home health service.

Supplementary Medical Insurance— Deductible and Coinsurance

245. INCURRED EXPENSES

The supplementary medical insurance plan (Part B) includes coverage for expenses incurred in connection with:

1. **Physician services**, including surgery, consultation, and home, office, and institutional calls.

Physician means a doctor of medicine or osteopathy (including osteopathic practitioner) legally authorized to practice by a State in which he performs this function.

A doctor of dental surgery or dental medicine with State authorization to practice is also a physician but only for surgery related to the jaw or any structure contiguous to the jaw, or the reduction of a fracture of the jaw or any facial bone. The coverage or exclusion of any given dental service is determined by the nature of the service, and not whether it was furnished by a dentist or a doctor of medicine. (See §§ 210.7 and 260.12 for additional information on covered and excluded dental services.)

The services performed by physicians within these definitions are subject to any limitations imposed by the State on the scope of practice.

Regardless of the actual expenses for physician services incurred in the treatment of mental, psychoneurotic, or personality disorders of persons who are not inpatients of hospitals, the amount of such expenses that can be counted in a calendar year is limited to the lesser of \$312.50 or 62.5 percent of the actual expenses. This limitation does not apply to **provider** services furnished in connection with the treatment of mental, psychoneurotic, or personality disorders.

2. **Services and supplies** furnished incident to a physician's services of the kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in physicians' bills.

3. **Home health services** for up to 100 visits during a calendar year. (These are in addition to the 100 visits payable under hospital insurance.)

4. **Outpatient diagnostic service deductibles** imposed under the hospital insurance plan (Part A) for diagnostic studies during the calendar year. (See § 248 for further explanation of the outpatient hospital diagnostic deductible as an incurred expense under supplementary medical insurance.)

5. **Other medical and health services.**

246. DEDUCTIBLE

In each calendar year a deductible of \$50 must be satisfied before payment can be made under the supplementary medical insurance plan. Under a carry-over provision, expenses incurred in the last 3 months of the previous year **which were applied toward the medical insurance deductible for that year**, may also be applied against the deductible for the current year. Except to the extent that the prior year's expenses are counted, the deductible is satisfied by the initial medical insurance expenses incurred in the current year.

Bills count toward the deductible on the basis of incurred, rather than paid expenses. Noncovered expenses do not count toward the deductible. Even though an individual is not eligible for the entire calendar year, i.e., his insurance coverage begins after the first month or he dies before the last month of the year, he is still subject to the full \$50 deductible. Medical expenses incurred in the portion of the year preceding entitlement to medical insurance may not be credited toward the deductible.

247. COINSURANCE

After the deductible has been satisfied providers will be paid 80 percent of the reasonable costs, and physicians and other suppliers 80 percent of the reasonable charges, incurred during the balance of the calendar year. When payment is made on the patient's behalf, the patient is responsible for a coinsurance amount equal to 20 percent of the reasonable charges for the items and services furnished.

248. OUTPATIENT HOSPITAL DIAGNOSTIC DEDUCTIBLE AS AN INCURRED EXPENSE UNDER THE SUPPLEMENTARY MEDICAL INSURANCE PLAN

The amount of any outpatient hospital diagnostic services deductible(s) (§ 236.2) incurred by an individual during the calendar year under hospital insur-

ance, is included as an incurred expense under supplementary medical insurance. It may be used to help satisfy the medical insurance deductible, and it is reimbursable under medical insurance if that deductible has been satisfied. Payment for this incurred expense, or crediting it toward the Part B deductible, is a responsibility of the hospital insurance intermediary.

The outpatient diagnostic deductible is the only exception to the rule that payment for services may not be made under medical insurance if the patient was entitled (except for the deductibles and coinsurance) to have payment made for those services under hospital insurance.

A hospital need not charge the full amount of the Part A outpatient hospital diagnostic deductible if the patient has already satisfied the \$50 Part B deductible. The hospital's record may indicate that the Part B deductible is met, or the patient may have a utilization notice (see § 304) which shows this. The hospital would charge the patient only 20 percent of his total bill for the study, and any other outpatient services furnished. The outpatient diagnostic deductible will be considered a medical insurance item and the hospital will be reimbursed for 80 percent of it under Part B.

If the hospital collects the full amount of the outpatient diagnostic deductible from the patient because it is not aware that the Part B deductible has been met, the intermediary will reimburse the patient for 80 percent of the Part A deductible amount he paid. (See § 420 for billing information and examples.)

Hospital-Based Physicians

255. HOSPITAL-BASED PHYSICIANS' SERVICES

The medical insurance program covers the reasonable charges for physicians' services rendered to individual beneficiaries. (The services of interns and residents, however, are reimbursable to the hospital on a reasonable cost basis even though the intern or resident is a licensed physician.) The charges of hospital-based physicians (e.g., those on salary) for services directed to the medical care of the individual patient, must be specially billed either by the physician or by the hospital on his behalf. However billed, reimbursement is made for medical services to individual patients on a reasonable charge basis by the supplementary medical insurance (Part B) intermediary.

(See § 430 for billing by the hospital for these services.)

Hospital-based physicians often perform services other than those clearly directed to the medical care of individual patients. These may involve teaching, autopsy, and administrative services, and other services that benefit the hospital's patients as a group. Such physician services, not directly related to an individual patient, if compensated, must be considered in computing reimbursable hospital costs and will be reflected in amounts payable to the hospital under Part A for such services rendered program beneficiaries.

Detailed information on reasonable cost and charge computation is contained in "Principles of Reimbursement for Services by Hospital-Based Physicians." These principles establish the criteria for distinguishing between the services of hospital-based physicians which are reimbursable as provider services and those services reimbursable as physicians' services to patients.

The principles also establish a basis for determining the reasonable charges for physicians' services to patients where, under the existing arrangement between the hospital and the physician, billings to patients have not separately identified charges for these services. Where charges for physicians' services to patients have been identified separately, the customary charges for physicians' services have been established and afford a basis for determining the reasonable charges for such services.

Finally, the principles establish a basis for ascertaining the customary charges for a physician's services to patients where, under a previous arrangement between the hospital and the physician, these services were not separately identified, but this arrangement is modified to provide for separate billing.

The hospital's Part A intermediary will obtain from the hospital information it and the Part B carrier need to make payment determinations for the services of hospital-based physicians. The Part A intermediary is responsible for reviewing and approving the reasonableness of the agreement between hospital and physician on the allocation of physician compensation, received from or through the hospital, between (1) the portion attributable to provider services, i.e., services to the institution and (2) the portion attributable to physician services, i.e., identifiable services rendered by the physician to individual patients.

If the hospital and physician fail to agree or if their agreement appears unreasonable, the Part A intermediary and the Part B carrier will jointly assist in resolving the issue. The Part B carrier is responsible

for review and approval, in accordance with the applicable principles, of the basis for Part B charges for services of hospital-based physicians, i.e., the schedule of such charges if the item-by-item method of determination is used, or the uniform percentage if the optional method of determination is used.

General Exclusions From Coverage

260. GENERAL EXCLUSIONS

No payment can be made under **either** the hospital insurance or supplementary medical insurance programs for the following items and services.

260.1 Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are not covered. Potential personal comfort items and services such as massages and heat lamp treatments are not covered unless they contribute meaningfully to the treatment of an illness or injury, or the functioning of a malformed body member.

260.2 Items and Services for Which There is No Legal Obligation to Pay.—Free services are excluded from coverage, e.g., free chest x-rays provided by health organizations.

This exclusion does not apply if the patient has a legal obligation to pay, or some other person or organization has a legal obligation to pay for or provide the items or services. Thus, benefits for covered items and services would be paid by the program even though the same services were covered by a prepayment plan or health insurance policy. Such a plan may pay money toward the cost of services or it may maintain its own facilities and professional supporting staff.

A legal obligation to pay exists even when reimbursement is expected only to the extent of the patient's insurance coverage.

In applying this exclusion the determining factor is that there is no legal obligation to pay for the items or services, and not merely the fact that the patient is not charged because of other considerations. This exclusion, therefore, does not prohibit program payment for services rendered to:

A. **Members of religious** orders who are not charged because of a vow of poverty;

B. **Indigents** who because of their inability to pay are not charged by an institution which customarily charges for such services;

C. **The patient whose need for services resulted from the act or negligence of another** who

is or may be legally liable for the patient's medical expenses. The existence of a third person's liability does not affect the patient's obligation to pay for the services he receives;

D. Certain residents of homes for the aged.—Coverage of health services furnished to a resident of a home for the aged depends on the agreement under which the services are provided.

1. The typical relationship between the **proprietary or profit-making home** and the residents is contractual. The home agrees to furnish or pay for certain services, including specified health services, in return for specified payments by the resident. Payment can be made under the health insurance program for the specified health services received by the resident of such a home since the home has a legal obligation to pay for or provide the services. Of course, payment may also be made for covered services not included in the resident's contract with the home, which he himself has a legal obligation to pay.

2. **Nonprofit homes** are generally operated by religious or fraternal organizations. The resident is ordinarily required to contribute to the cost of his maintenance and health care to the extent that he is able. For example, the resident is usually required to assign to the home assets or income at the time of admission. Where this is the case, payment can be made under the program for covered services furnished the resident whether or not his circumstances permitted him to pay anything for his care.

However, where all services are furnished by the home on a purely charitable basis (i.e., no payment is accepted from residents regardless of their ability to pay), payment could not be made under the health insurance program for items and services furnished by the home. In this situation, however, payment could be made for services furnished by a source independent of the home if that source customarily charges for such services. Thus, payment could be made for services furnished by a hospital or extended care facility to which a resident of the home is sent, or for home health services furnished by an agency, or for the services of a physician who is not an employee of the home.

3. **Certain union homes** accept no payment from residents regardless of their ability to pay. Payment may, nevertheless, be made for services provided by such homes where admission to the home and access to the services is a matter of right for union members who meet the necessary qualifications.

4. Homes for Members of Religious Orders.—Many religious orders maintain homes similar to retirement homes to care for members who become ill or infirm. Since members of the order are under a vow of poverty, there is no charge made by the home for this care. The order is considered to have an obligation to care for its members who have rendered lifelong services. Payment may be made for services furnished in these homes, whether they are furnished by the home itself or by independent sources that customarily charge for their services.

260.3 Items and services which are paid for by a governmental entity other than under a title of the Social Security Act, such as a medical assistance program, or under a health benefits or insurance plan for employees of the governmental entity are not covered. (Payment cannot be made under the health insurance program if the services are paid for by a National Institutes of Health grant or by the Veterans Administration Home Town Care Medical Program. However, when the option to have payment made under the health insurance program is exercised, the fact of eligibility under these other programs does not prevent payment under health insurance.) The Secretary of Health, Education, and Welfare may specify other exceptions to this exclusion. The Secretary has approved payment for covered items and services even though provided free:

A. If furnished by participating State or local government-operated hospitals, including psychiatric and tuberculosis hospitals which serve the general community. Payment may not be made for services in hospitals which serve only a special category of the population, such as prison hospitals, nor for services furnished to prisoners in hospitals serving the general community.

B. If paid for by a State or local governmental entity and furnished an individual as a means to control infectious diseases or to provide for the medically indigent. These services need not be furnished in a hospital. Payment may be made for items and services furnished by a government-operated home for the indigent aged whether supplied directly by the home or purchased by it from independent physicians and hospitals. Payment may also be made for services furnished by a participating State-operated Veterans' Home and Hospital, provided the patient would, in the absence of program coverage, have been charged for the items and services, or he was admitted to the facility without charge as an indigent.

260.4 Items and services which are not provided within the United States are not covered (except for emergency inpatient hospital services furnished outside the United States under the conditions described in § 202 and payment on behalf of railroad beneficiaries for covered hospital insurance services furnished in Canadian hospitals). The United States includes the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

260.5 Items and services which are required as a result of war, or of an act of war, occurring after the effective date of the patient's current coverage are not covered.

260.6 Personal Comfort Items.—Items which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member are not covered.

Charges for special items **requested** by the patient such as radio, television, telephone, and air conditioner, and beauty and barber services are excluded from coverage.

Items and services such as heat lamp treatments and massages are covered only when ordered by a physician.

260.7 Routine physical checkups; eyeglasses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; **hearing aids and examinations for hearing aids**; and **immunizations** are not covered.

Routine physical checkups include (a) examinations performed without relationship to treatment or diagnosis of a specific illness, symptom, complaint, or injury, and (b) examinations required by third parties such as insurance companies, business establishments, or Government agencies.

The exclusions apply to eyeglasses or contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors. The exclusions do not apply to services performed in conjunction with an eye disease such as glaucoma or cataracts, nor to postsurgical prosthetic lenses which are customarily used during convalescence from eye surgery in which the lens of the eye was removed, nor to the permanent prosthetic lenses required by an individual lacking the organic lens of the eye, whether by surgical removal or congenital absence. Such prosthetic lens is a replacement for an internal body organ—the lens of the eye. (§ 240.2B2.)

Vaccinations or inoculations are excluded as “immunizations” unless they are directly related to the

treatment of an injury or direct exposure such as anti-rabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin.

260.8 Orthopedic Shoes or Other Supportive Devices for the Feet.—The exclusion of orthopedic shoes does not apply to such a shoe if it is an integral part of a leg brace.

260.9 Custodial Care.—The custodial care exclusion precludes payment for that type of care, wherever furnished, which is designed essentially to assist the individual in meeting his activities of daily living—i.e., services which constitute personal care such as help in walking and getting in or out of bed, assistance in bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision over medication which can usually be self-administered—and which does not entail or require the continuing attention of trained medical or paramedical personnel.

260.10 Cosmetic surgery or expenses incurred in connection with such surgery are not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, nor to surgery for therapeutic purposes, which coincidentally also serves some cosmetic purpose.

260.11 Charges imposed by immediate relatives of the patient or members of his household are not covered.—**Immediate relative** as used in this exclusion means spouse, father, mother, son, daughter, brother, or sister—by blood, marriage, or adoption. **Members of the patient's household** means those persons sharing a common abode with the patient as part of a single family unit, including those related by blood or marriage, domestic employees, and others who live together as part of a single family unit. A mere roomer or boarder is not included.

Where a business enterprise imposes the charge, the exclusion applies if the firm in fact represents an individual within these relationships. If an individual proprietorship is involved, the proprietor is considered the individual imposing the charge. A corporation is a separate legal entity which cannot be a member of a household or an immediate relative. Charges imposed by a partnership are not excluded unless all of the partners are within the designated relationships to the patient.

260.12 Items and services in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth are not covered. "Structures directly supporting the teeth" means the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth, and alveolar process.

Payment may be made, however, for (a) surgery related to the jaw or any structures contiguous to the jaw, or (b) the reduction of any fracture of the jaw or any facial bone, including dental splints or other appliances used for this purpose.

The hospitalization or nonhospitalization of a patient has no direct bearing on the coverage or exclusion of a given dental procedure. (See also §§ 210.7 and 245 for additional information on dental services.)

260.13 Items and services to the extent that payment has been made, or can reasonably be expected to be made **under a workmen's compensation law** or plan of the United States or a State may not be paid for by the program. Payments for items and services under the health insurance program are subject to repayment to the appropriate trust fund if notice or information is received that payment has been made for the items and services under a workmen's compensation plan. (See §§ 289 ff.)

260.14 Items or services which the provider is obligated by a law of or because of a contract with the Federal Government ~~to render for public expense~~ are not covered. This exclusion applies to services furnished to veterans pursuant to a contract with the Veterans Administration.

260.15 Items and services are not covered when furnished by a Federal provider of services or other Federal agency except (a) for emergency inpatient hospital services and emergency outpatient hospital diagnostic services furnished by a Federal hospital meeting the requirements of § 202, or (b) when the Federal provider of services is determined by the Secretary of Health, Education, and Welfare to be providing services to the public generally as a community institution or agency.

Requirements for Payment

270. REQUEST FOR PAYMENT

Before payment can be made for an inpatient hospital stay, outpatient hospital diagnostic study, hospital services under medical insurance, or physicians' services billed through the hospital, a written request for payment signed by the patient, or by another person quali-

fied to do so on his behalf must be filed. The signature of the patient or other qualified person may be obtained on the respective billing forms, or, under specified conditions, the hospital may obtain a single signature on its records.

If a fully competent and capable patient **refuses** to sign the request for payment necessary for the hospital to obtain reimbursement for the services it furnished, the hospital may charge the patient or other person for the covered services.

270.1 Billing Forms as Request for Payment.—Each of the billing forms (Inpatient Hospital Admission and Billing, Form SSA-1453; Inpatient Psychiatric or Tuberculosis Hospital Admission and Billing, Form SSA-1485; Outpatient Hospital Billing, Form SSA-1483; and Provider Billing for Patient Services by Physicians, Form SSA-1554) contains a patient's signature line incorporating the patient's request for payment of benefits, authorization to release information and assignment of benefits. When the billing form is used as the request for payment, the billing form must be signed. The request for payment will then be forwarded to the intermediary or, to the Social Security Administration where the hospital deals directly with the Government, when the hospital submits its bill.

A. The billing form as request for payment will be signed in connection **with each inpatient hospital admission**, even though multiple admissions may occur during the same spell of illness. Only one request for payment has to be signed, however, in connection with each inpatient admission, even though an extended hospital stay occasions multiple billings.

B. Where the billing form is used as the request for payment for **physicians' services billed through the hospital for outpatient diagnostic studies and for other outpatient hospital services**, a signature is required with each billing by the hospital.

270.2 Request for Payment on Hospital Record.—In lieu of separate signatures on the billing forms, the hospital may arrange with its hospital insurance intermediary to have the patient's signature on its admission records serve as the request for payment.

The pertinent language on the billing forms must be incorporated, by printing or stamp, either in the hospital's own admission forms, or on a separate form attached to or associated with the hospital's admission form. Where this procedure is adopted, "Patient's request for payment on file" should be stamped on the patient's signature line of the original of the billing form to indicate that the patient's statement is on file.

When the hospital has arranged with its hospital insurance intermediary to put this procedure into effect, the intermediary will make payment to the hospital without the patient's signature on the billing form. The Part A intermediary will verify through its regular audit activities that the signatures are being obtained as specified. The medical insurance carrier will rely on the Part A intermediary's administration of this procedure and will make payment to a hospital without the patient's signature on the form SSA-1554.

The following format is suggested for the statement on the hospital's record:

"Statement to Permit Payment of Hospital and Medical Insurance Benefits to Hospital

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made in my behalf.

I assign payment for the unpaid charges of the physician(s) for whom the hospital is authorized to bill in connection with its services. I understand I am responsible for any health insurance deductibles and 20 percent of the remaining reasonable charges.

For outpatient services, I request that this authorization apply to the period ----- to -----."

Where the hospital does not bill on behalf of its hospital-based physicians, the assignment part of the above statement should be omitted. Where a patient does not want to assign the benefits for services of a hospital-based physician, the assignment language should be lined out in that particular case.

A. **For inpatient billing**, the patient's signature will cover only that particular stay regardless of its duration. When the patient is admitted for a new inpatient stay, another request for benefits is required.

B. **For outpatient billing**, the designated period of time to be entered in the statement on the hospital record should be appropriate to the circumstances. Where there is an outpatient hospital admission with repeated visits expected, a period deemed to correspond with the anticipated period of treatment may be entered but not to exceed 1 year. Some hospitals may prefer to restrict the period to accommodate their own admission or billing requirements.

C. **When hospital-based physician services are billed** under this procedure, the effective period of the patient's signature will be the same as that for the re-

lated inpatient or outpatient billing. Thus, the patient's signature will cover all Form SSA-1554's filed in connection with a single inpatient stay, or for services in the designated outpatient billing period.

271. EXECUTION OF THE REQUEST FOR PAYMENT

If at all practicable, the patient should sign the request either on the billing form or on the hospital's record at the time of admission. (See Admission Procedures, §§ 300 ff.)

In certain circumstances, it would be impracticable for an individual to sign the request for payment himself because when he is admitted to the hospital, or begins outpatient hospital diagnostic or other hospital services, he is unconscious, incompetent, in great pain, or otherwise in such a condition that he should not be asked to transact any business. In this situation, his representative payee (i.e., a person designated by the Social Security Administration to receive monthly benefits on the patient's behalf), a relative, legal guardian, or a representative of an institution (other than the hospital) usually responsible for his care, or a representative of a governmental entity providing welfare assistance should, if present at time of admission, be asked and permitted to sign on his behalf.

When no request for payment is obtained at the time of admission, the hospital should attempt to obtain such a request later from the patient or other person described above. If the request cannot be so obtained by the time the hospital would ordinarily submit its bill to the intermediary, an authorized official of the hospital may sign the request.

When someone other than the patient signs the request for payment, have the signer briefly state his relationship to the patient and the circumstances which made it impracticable for the patient to sign. The hospital will forward this statement on or with its billing, or retain it in its files if the signature is obtained on its own record. The intermediary will generally accept such a statement as true in the absence of evidence to the contrary.

In some cases of outpatient diagnostic services, whether furnished under Part A or Part B, the hospital need not attempt to obtain the patient's signature. This is the situation in which the physician sends a specimen (e.g., blood or urine sample) to a laboratory of a participating hospital for analysis. The patient himself does not go to the hospital, but the tests are billed through it. The hospital may sign on behalf of the patient and should note in the space provided

for the patient's signature on the Outpatient Hospital Billing (SSA-1483) and any accompanying Provider Billing for Patient Services by Physicians (SSA-1554), "Patient not physically present for tests." This does not apply when the patient actually goes to the hospital for tests and the hospital fails to obtain his signature while he is there.

Except in the outpatient case where the patient is not physically present, the hospital should not routinely sign the request on behalf of any patient. If experience reveals an unusual frequency of such hospital signed requests from a particular hospital, the matter will be subject to review by the intermediary.

Certification and Recertification by Physicians

273. CERTIFICATION AND RECERTIFICATION BY PHYSICIANS—GENERAL

Payment may be made for covered hospital services only if a physician certifies to the medical necessity for the services. For services continued over a period of time, a physician must recertify the continued need for the services at specified intervals. Appropriate supporting material may be required.

Hospitals will not transmit physician certification and recertification statements to the intermediary, or to the Social Security Administration if the hospital deals directly. The hospital must itself certify, on the appropriate billing form, that the required physician certification and recertification statements have been obtained and are on file. The physician certification and recertification statements will be retained in the hospital's files where they will be available for verification if needed.

A hospital must also have available in its files a description of the procedure it adopts on the timing of recertifications—that is, the intervals at which recertifications will be required and whether review of long-stay cases by the utilization review committee will serve as an alternative to recertification by a physician in the case of the third or subsequent recertifications.

273.1 Failure to Certify or Recertify.—If a hospital fails to obtain the required certification and recertification statements in an individual case, program payment cannot be made in that case.

If the hospital's failure to obtain a certification or recertification is not due to a question as to the necessity for the services, but rather to the physician's

refusal to certify based on other grounds (e.g., he objects in principle to the concept of certification and recertification), the hospital may not charge the beneficiary for any covered items or services furnished him. The provider agreement which the hospital files with the Secretary precludes it from doing so.

If a physician refuses to certify because, in his opinion, hospitalization was not required for medical treatment or diagnostic study, the services are not covered and the hospital can bill the patient directly. The reason for the physician's refusal to make the certification must be documented in the hospital records.

274. INPATIENT HOSPITAL SERVICES CERTIFICATION

The inpatient hospital services certification should state the medical necessity for inpatient hospital admission. It is not necessary to state the reason(s) why hospital admission is necessary.

The certification of the medical necessity for inpatient hospital services must be signed by the admitting physician or a medical staff member with knowledge of the case. The routine admission procedure followed by a physician would not ordinarily of itself be sufficient certification of the medical necessity for hospitalization for purposes of the program.

When a patient is hospitalized for a **covered** dental procedure (see §§ 210.7 and 260.12), the dentist is a "physician" (§ 245) and may certify and recertify to the medical necessity for inpatient hospital services. If a patient must be hospitalized for a **noncovered** dental procedure because he has a nondental impairment, e.g., a heart condition, the physician responsible for the treatment or management of the nondental impairment must certify to the necessity for the patient's hospitalization for the impairment.

Certifications must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable. However, the individual hospital determines the method by which certifications are to be obtained and the format of the certification statement. Thus, the medical and administrative staffs of each hospital may adopt the procedure they find most convenient and appropriate.

There is no requirement that the certification be entered on any specific form or handled in any specific way, as long as the approach adopted by the hospital permits the intermediary (or the Social Security Administration where the hospital deals directly with the Government) to de-

termine that the certification requirement is in fact met. The certification could, therefore, be entered or preprinted on a form the physician already has to sign; or a separate certification form could be used.

275. RECERTIFICATION FOR INPATIENT HOSPITAL SERVICES

The recertification statement must meet the following standards: it must contain an adequate written record of the reasons for continued hospitalization, the estimated period of time the patient will need to remain in the hospital, and plans for posthospital care. The recertification statement made by the physician has to meet the content standards unless, for example, all of the required information is included in progress notes, in which case the physician's statement could indicate that the individual's medical record contains the information required by the standards and that continued hospitalization is medically necessary.

A physician who recertifies to the need for continued inpatient stay should use the same criteria that apply to the hospital's utilization review committee. Where the basis for the recertification is the need for continued inpatient care because of the lack of extended care facility accommodations (§ 290.3), the recertification should so state. The physician should attempt on a continuing basis to place his patient in a participating extended care facility as soon as a bed becomes available.

Recertifications are to be signed by the attending physician or a medical staff member with knowledge of the case. The hospital determines the form of the written record and the manner of obtaining timely recertifications. Thus, the hospital is able to adopt a procedure for obtaining timely recertifications that suits it best.

Where the requirements for the third or a subsequent recertification are satisfied by review of a stay of extended duration, pursuant to the hospital's utilization review plan, a separate recertification statement is not required. However, it is necessary to satisfy the recertification content standards. It would be sufficient if records of the utilization review committee show that consideration was given to the three items mentioned above—the reasons for continued hospitalization, estimated time the patient will need to remain in the hospital, and plans for posthospital care.

276. TIMING OF RECERTIFICATIONS

The **first recertification** is required no later than as of the 14th day of hospitalization. A hospital may,

at its option, provide for the first recertification to be made earlier, or it may vary the timing of the first recertification within the 14-day period by diagnostic or clinical categories.

A **second recertification** is required no later than as of the 21st day of hospitalization. Thereafter, **subsequent recertifications** must be made at intervals established by the utilization review committee (on a case-by-case basis if it so chooses), but in no event may the prescribed interval between recertifications exceed 30 days. The utilization review committee will be reviewing long-stay cases and may be in the best position to decide when subsequent recertifications are needed.

A hospital can, if it wishes, coordinate its physician certifications with the process of review by the utilization review committee of long-stay cases. At the option of a hospital, review of a stay of extended duration under the hospital's utilization review plan may take the place of the third and any subsequent physician recertifications. (Such review may be the initial review, or a second or subsequent review of an extended-stay case by the utilization review committee.)

Where review of an extended-stay case by the utilization review committee is deemed to take the place of a physician recertification, it would be possible for the recertification to be made later than the specified day, because the review of an extended duration case may be made at any time within the 7-day period following the last day of the period of extended duration defined in the utilization review plan. Such a recertification will be treated as a delayed recertification, however, no explanation for the normal delay is required.

277. INPATIENT PSYCHIATRIC HOSPITAL SERVICES CERTIFICATION AND RECERTIFICATION

The requirements for physician certification and recertification for inpatient psychiatric hospital services are generally the same as for inpatient hospital services. However, the required content of the certification and recertification statements differs from the content of the statements required for inpatient hospital services.

The **certification** should state that the inpatient psychiatric hospital admission was medically necessary, for either (1) treatment which could reasonably be expected to improve the patient's condition, or (2) diagnostic study.

The **recertification** should state (1) that inpatient psychiatric hospital services furnished since the previous certification or recertification were, and continue to be, medically necessary for either (a) treatment which could reasonably be expected to improve the patient's

condition, or (b) diagnostic study; and (2) that the hospital records indicate that the services furnished were either intensive treatment services, admission and related services necessary for diagnostic study, or equivalent services.

For convenience, the period covered by the physician's certification and recertification is referred to as a period during which the patient was receiving **active treatment**. If the patient remains in the hospital but the period of "active treatment" ends (e.g., because the treatment cannot reasonably be expected to improve the patient's condition, or because intensive treatment services are not being furnished), program payment can no longer be made even though the patient has not yet exhausted his benefits. Where the period of "active treatment" ends, the physician is to indicate the ending date in making his recertification. If "active treatment" thereafter resumes, the physician should indicate, in making his recertification, the date on which it resumed.

278. INPATIENT TUBERCULOSIS HOSPITAL SERVICES CERTIFICATION AND RECERTIFICATION

The requirements for physician certification and recertification for inpatient tuberculosis hospital services are generally the same as for inpatient hospital services. However, the required content of the certification and recertification statements differs from the content of the statements required for inpatient hospital services.

The **certification** should state that the inpatient tuberculosis hospital admission was medically necessary for treatment which could reasonably be expected either to (1) improve the patient's condition, or (2) render the condition noncommunicable.

The **recertification** should state (1) that the inpatient tuberculosis hospital services furnished since the previous certification or recertification were, and continue to be, medically necessary for treatment which could reasonably be expected either to (a) improve the patient's condition, or (b) render the condition noncommunicable; and (2) that the hospital records indicate such medical necessity.

For convenience, the period covered by the physician's certification and recertification is referred to as a period during which the patient was receiving **active treatment**. If the patient remains in the hospital but the period of "active treatment" ends (e.g., because the treatment cannot reasonably be expected to improve the patient's condition), program payment can no longer be made even though the patient has not yet exhausted

his benefits. Where the period of "active treatment" ends, the physician is to indicate the ending date in making his recertification. If "active treatment" thereafter resumes, the physician should indicate, in making his recertification, the date on which it resumed.

279. OUTPATIENT HOSPITAL DIAGNOSTIC SERVICES CERTIFICATION

A physician should state that outpatient hospital diagnostic services are required for a diagnostic study.

Certification as to outpatient diagnostic services may be made on the physician's orders, on the copy of the summary prepared at the conclusion of the study that is retained by the hospital, or a special form may be used.

Recertification is not required for outpatient hospital diagnostic services. However, if the diagnostic service extends beyond 20 days, a new certification is required for each study period.

280. CERTIFICATION FOR HOSPITAL SERVICES COVERED BY THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

A physician must certify that the medical and other health services covered by medical insurance which were provided by (or under arrangements made by) the hospital were medically required.

When the hospital provides ambulance service to transport the patient from the scene of an accident and no physician is involved until the patient reaches the hospital, any physician in the hospital who examines the patient or has knowledge of the case may certify to the medical need for the ambulance service.

This certification requires a brief description of the services and the signature of the physician. It need be made only once for a course of treatment. Where services are provided on a continuing basis, such as a course of radium treatments, the physician's certification may be made at the beginning or end of the course of treatment, or at any other time during the period of treatment.

There is no requirement that the certification be entered on any specific form or handled in any specific way, as long as the approach adopted by the hospital permits the intermediary (or the Social Security Administration where the hospital deals directly with the Government) to determine that the certification requirement is in fact met. The certification could, therefore, be entered or preprinted on a form the physician already has to sign; or a separate certification form could be used.

281. DELAYED CERTIFICATIONS AND RECERTIFICATIONS

Hospitals are expected to obtain timely certification and recertification statements. However, delayed certifications and recertifications will be honored where, for example, there has been an oversight or lapse.

In addition to complying with the appropriate content requirements, delayed certifications and recertifications must include an explanation for the delay and any medical or other evidence which the hospital considers relevant for purposes of explaining the delay. The hospital will determine the format of delay certification and recertification statements, and the method by which they are obtained. A delayed certification and recertification may appear in one statement; separate signed statements for each certification and recertification are not required as they would be if timely certification and recertification had been made.

282. TIMING OF CERTIFICATION AND RECERTIFICATION FOR BENEFICIARY ADMITTED BEFORE ENTITLEMENT

If an individual is admitted to a hospital (including a psychiatric or tuberculosis hospital) before he is entitled to hospital insurance benefits (for example, before he reaches age 65), the following rules apply when he does become entitled.

No certification as to the medical necessity for inpatient admission is required. Recertifications are required as of the time they would be required if the patient had been admitted to the hospital on the day he became entitled. For example, if a patient becomes entitled to Part A benefits on May 1, but was admitted prior to that date, the first recertification is required no later than May 14; the second recertification is required no later than May 21; subsequent recertifications are required at intervals not to exceed 30 days.

Psychiatric and Tuberculosis Hospital Records

283. PSYCHIATRIC AND TUBERCULOSIS HOSPITAL RECORDS

The law requires that psychiatric and tuberculosis hospital records contain certain specific information concerning the individual patient's condition and the nature of the treatment provided.

283.1 In the case of **inpatient psychiatric hospital services** the hospital records must show that the services were furnished to the patient during periods

when he was receiving intensive treatment services, admission and related services necessary for a diagnostic study, or equivalent services. As noted in § 277, the physician recertification for inpatient psychiatric hospital services must include a statement that the hospital records so indicate.

283.2 In the case of **inpatient tuberculosis hospital services** the hospital records must show that the services were furnished to the patient during periods when he was receiving treatment (including diagnostic services) which could reasonably be expected to improve his condition or render it noncommunicable. As noted in § 278, the physician recertification for inpatient tuberculosis hospital services must include a statement that the hospital records so indicate.

Special Provisions Related to Payment

285. REFUNDS

In its participation agreement, the hospital agrees not to charge for items or services for which an individual is entitled to have payment made on his behalf, and to make adequate provision for return (or other disposition) of any money incorrectly collected from an individual or from any other person on his behalf (e.g., other insurance carriers or welfare).

Money incorrectly collected means amounts in excess of the deductible or coinsurance, paid to a hospital by or on behalf of an individual for covered items and services for which he is entitled to have payment made under the health insurance program.

Incorrect collections may result from billing a beneficiary in error for a covered item or service; or from retroactive entitlement; or workmen's compensation cases in which the beneficiary has paid for covered services to which he later becomes entitled under health insurance. A claim for payment under the guarantee of payment provision (§ 286) may also involve sums incorrectly collected.

Where the intermediary knows that a hospital has overcollected deductible and coinsurance amounts for outpatient hospital services, it will make direct refund to the beneficiary. (See § 420.)

285.1 Return or Other Disposition of Money Incorrectly Collected.—A hospital that has incorrectly collected is required to refund or set aside the money. Until the hospital refunds or sets aside the money incorrectly collected, an equivalent amount may be withheld from payments otherwise due the hospital.

A. Making Refund.—Refund is to be made to the beneficiary, or any other person from whom the hospital collected the money. If the proper person cannot be located after reasonable effort (including an attempt at contact **by mail** at the last known address), the hospital should request the intermediary to have the Social Security Administration's records examined for the individual's address. If the individual still cannot be located, or he is dead, the hospital is to dispose of the money in accordance with the law of the State in which it is located.

B. Money Set Aside.—Where the individual's whereabouts are unknown, there is a delay in the appointment of a legal representative of the estate of a deceased individual, and other cases in which refund may be delayed indefinitely, the hospital will notify the intermediary and will set the funds aside in a separate account identified by the name of the individual to whom the payment is due. These accounts will be carried on the hospital's records in this manner until final disposition is made under the applicable State law.

C. Time Limits Within Which Hospital Action Must Be Taken.—The incorrect collection should be refunded as promptly as possible. If refund cannot be made within 60 days after the date of the notice to the hospital that an incorrect collection was made, the funds must be set aside as described in B above.

286. GUARANTEE OF PAYMENT PROVISIONS

A hospital may be paid, under certain conditions, for inpatient hospital services furnished to a beneficiary whose eligibility for inpatient hospital benefit days in a spell of illness has been exhausted. The guarantee also extends to inpatient psychiatric hospital services furnished to an individual who has used up his 190-day lifetime limitation on such services. (The guarantee extends **only** to inpatient services furnished to individuals who have exhausted their eligibility for inpatient services. It does not extend to individuals who have no coverage for other reasons, e.g., one who is not entitled under the hospital insurance program, or whose entitlement has been terminated.) The provision assures at the time of admission that payment will be made to a hospital for its services during the time it takes to notify the hospital of the patient's utilization record.

The guarantee includes not only cases in which inpatient benefits were already exhausted prior to ad-

mission, but cases where a beneficiary had some inpatient hospital benefits remaining at the time of his admittance to a hospital, e.g., 2 or 3 days of remaining eligibility, but these benefits are exhausted before the intermediary's reply to the Notice of Admission reaches the hospital. Payment under the guarantee, i.e., for those days after benefits are exhausted, is made at the full rate. The coinsurance provision does not apply.

The guarantee applies only to inpatient hospital services. It does not apply to other benefits provided under the hospital or medical insurance programs. A hospital is not required to claim payments under this provision; it may look to the patient for payment.

286.1 Requirements for Payment Under the Guarantee.—The following conditions must be met for a hospital to receive payments under this provision. The hospital should submit an explanation of the circumstances with its bill.

A. The services provided by the hospital are covered inpatient hospital services.

B. The hospital acted in good faith in assuming that the individual was entitled to inpatient hospital benefits. If it is found that the hospital acted reasonably, in accordance with C below, it will generally be presumed to have acted in good faith. There would be an absence of good faith if the hospital had, or should have had, a substantial doubt that coverage existed.

C. There were reasonable grounds for the hospital to assume that entitlement to benefits existed. The hospital will have acted reasonably if it tried to find out the extent of the beneficiary's entitlement to inpatient hospital services by:

1. Asking the beneficiary or another person if the beneficiary was an inpatient of a hospital or extended care facility within the past 60 days; and

2. Requesting, if there was a prior stay, the additional information from the beneficiary or other person necessary to indicate the number of days of inpatient hospital services, if any, remaining in the current spell of illness.

3. Under unusual circumstances, reasonable grounds may be found even though the hospital has not followed the requirements of 1 and 2 above (e.g., because the patient was not in a physical or mental condition to discuss his entitlement and no other person with a knowledge of his affairs was available).

D. Prior to submitting its bill under the guarantee provision, the hospital refunds amounts received from the patient, or someone on his behalf, for the services for which the program is being billed. If the hospital

retains all or part of the payment made by the patient or someone on his behalf for services within the guarantee period it should not claim program payment for the amounts it has retained. Where the guarantee applies, the hospital should furnish an itemized statement of payments received and refunds made in connection with the bill.

286.2 Maximum Number of Days Under Guarantee.—The intermediary (or the Social Security Administration) may pay the hospital for inpatient hospital services furnished for up to 6 days after the day of admission. Saturdays, Sundays, legal Federal holidays, and the first calendar day of admittance to the hospital will be omitted in computing the 6 elapsed days. However, no payment is made for any day after the day the hospital receives a notice of lack of entitlement. The notice may be furnished by mail, messenger, wire, or telephone. If notice is given by telephone, a confirmation in writing will be furnished to the hospital; the date of the telephone message will be considered the date of notification.

In determining the days covered by the guarantee, legal Federal holidays are:

- New Year's Day
- Washington's Birthday
- Memorial (Decoration) Day
- Independence Day
- Labor Day
- Veterans Day
- Thanksgiving Day
- Christmas Day

Exclusion of Federal nonworking days prolongs the period covered by the guarantee. When a Federal holiday occurs on a Sunday, the day following is observed as a Federal nonworkday and, therefore, would not be counted as an elapsed day. When the holiday falls on Saturday, the prior Friday would not be counted as an elapsed day. The hospital will be paid on behalf of the beneficiary for all the days of inpatient services within the guarantee period; i.e., weekends, holidays, and the day of admittance will be included in computing the benefit amount due the hospital.

286.3 Recovery of Funds Advanced Under Guarantee Provision.—Benefits paid to hospitals under the guarantee provision are subject to recovery from the beneficiary unless recovery is waived. Cash benefits payable to the beneficiary under the Social Security or Railroad Retirement Act may be suspended or reduced until the amount advanced to the hospital on his behalf has been repaid.

289. WORKMEN'S COMPENSATION

Health insurance payment is excluded for any items and services to the extent that payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State. This exclusion applies to the workmen's compensation plans of the 50 States, the District of Columbia, and Puerto Rico, and to the Federal Employees Compensation Act and the Longshoremen's and Harbor Workers' Compensation Act. The Federal Employers' Liability Act is not a workmen's compensation law or plan under this exclusion.

Health insurance payment for items or services is conditioned on reimbursement to the hospital or supplementary medical insurance trust fund when notice or other information is received that payment has been made under workmen's compensation.

The individual is responsible for taking whatever action is necessary to obtain payment under workmen's compensation where such payment can reasonably be expected. If he fails to take proper and timely action, health insurance payment will not be made for services that **could** have been paid for under workmen's compensation. The hospital should advise the patient to file for workmen's compensation when a work-related injury or illness is indicated.

289.1 Effect of Workmen's Compensation Payments on Eligibility and Spell of Illness.—An inpatient stay in a qualified hospital or extended care facility starts a spell of illness even though workmen's compensation, rather than the health insurance program, pays or can be expected to pay for the services.

However, there is no charge against the patient's 90 days of benefit eligibility, nor the 190-day lifetime limitation on inpatient psychiatric hospital services, for days covered by workmen's compensation. When workmen's compensation pays for part of a stay and health insurance pays for services thereafter, only the days for which health insurance paid are charged against the individual's benefit eligibility.

Workmen's compensation payments cannot be counted toward the health insurance deductibles or coinsurance under either Part A or Part B. For example: If an individual is hospitalized twice in the same spell of illness and the first stay is completely paid for under workmen's compensation, the inpatient hospital deductible applies to the second stay.

289.2 General Procedures in Workmen's Compensation Cases.—An employment related illness or injury is indicated on the billing form, and the employer's name and address given.

If the patient has already received a workmen's compensation payment for the current illness or injury (e.g., for a prior hospital stay), the hospital should furnish the intermediary any available information with the admission notice, since a later hospitalization for the same condition may also be compensated under workmen's compensation. If workmen's compensation coverage is possible, a claim should be filed with the workmen's compensation carrier.

Even though workmen's compensation payment has been or probably will be made, the hospital should submit a bill to the intermediary, or to the Social Security Administration if the hospital deals directly with the Government (see § 450).

A. Workmen's Compensation Has Been or Is Being Paid.—If at the time the hospital submits its bill, workmen's compensation payment, which fully covers the cost of the services furnished, has been or is being made, no health insurance payment can be made.

A lump sum compromise awarded as payment of a workmen's compensation claim may include an amount for hospital and medical expenses. The payment under health insurance in such cases is based on the intermediary's judgment as to what workmen's compensation could reasonably have been expected to pay had the individual pursued his rights rather than accepting the compromise settlement.

The hospital will be notified by the intermediary of the extent to which its bill was covered by workmen's compensation.

B. Workmen's Compensation Is Reasonably Expected.—If, at the time the hospital submits its bill, workmen's compensation has not been or is not being paid, the intermediary will determine whether workmen's compensation can reasonably be expected to pay. If the intermediary determines that workmen's compensation payment can reasonably be expected, the hospital will be notified that health insurance payments cannot be made. The individual will also be notified of the intermediary's decision. If workmen's compensation does not ultimately pay for the services, the claim under health insurance may be reopened.

C. Workmen's Compensation Is Questionable.—If the intermediary determines that workmen's compensation payments cannot reasonably be expected, payment under health insurance will be made to the hospital on condition that the payment will be refunded if workmen's compensation later pays for the services. However, conditional payment will not be made unless there is a real question as to workmen's compensation payment. The mere fact that the em-

ployer or the workmen's compensation carrier is contesting liability is not in itself sufficient basis for conditional payment.

289.3 Overpayments.—If the hospital receives workmen's compensation payments after having received health insurance payments for the same items and services, the program must be reimbursed for the overpayment. The hospital may arrange with the intermediary to do this by refund or by adjustment of its future program payments.

290. UTILIZATION REVIEW PLAN

A qualified hospital is required to have in effect a plan for utilization review which applies to the inpatient services the hospital furnishes to patients entitled to benefits under the health insurance program. The plan must provide for review, on a sample basis, of admissions, duration of stays, and professional services furnished; and review of each case of continuous extended duration while the patient is in the hospital.

If the hospital's utilization review committee has reason to believe that an inpatient admission was not medically necessary, it may review the admission at any time. However, the decision of a utilization review committee in one hospital is not binding upon the utilization review committee in another hospital.

Payments made to physicians serving on hospital utilization review committees are considered as an allowable hospital cost **only** if the utilization review plan applies to **all** of the hospital's inpatients.

The law requires that effective utilization review be maintained on a continuing basis to assure the medical necessity of the services for which the program pays and promote the most efficient use of available health facilities and services.

The detailed requirements for an acceptable utilization review plan are set out in the "Conditions of Participation for Hospitals."

290.1 Definition of Extended Stay—Beneficiary Admitted Before Entitlement.—The general rule for the review of extended-stay cases is explained in the "Conditions of Participation for Hospitals." If an individual is admitted to a hospital before he is entitled to hospital insurance benefits (for example, before he reaches age 65), the following rules apply when he does become entitled.

In identifying cases of extended duration for review by the utilization review committee in those hospitals which provide for the review of beneficiary cases only, the patient will be considered to have been admitted to the hospital on the day he became entitled to hos-

pital insurance benefits. For example, if a hospital has defined extended stay as being 20 days of hospitalization, a patient who becomes entitled to Part A benefits on May 1, but who is admitted prior to that date, would be considered as an extended-stay case for utilization review purposes on May 21.

290.2 Further Inpatient Stay Not Medically Necessary.—If in the review of an extended-stay case the physician members of the utilization review committee decide, after opportunity for consultation is given the attending physician, that further inpatient stay is not medically necessary, notification in writing is given within 48 hours to the institution, the attending physician, and the patient. While the attending physician may, if he wishes, advise the patient personally of the utilization review committee's decision, it would still be necessary for the committee to give timely written notice of its decision to the patient. Payment cannot be made for more than 3 days of inpatient hospital services after the date the notice is received by the hospital.

290.3 Availability and Appropriateness of Other Facilities and Services.—In determining whether further inpatient hospital stay is medically necessary, utilization review committees are required to take into account the availability and appropriateness of other facilities and services. The following guidelines should be used by utilization review committees in general hospitals. (Instructions for committees in psychiatric and tuberculosis hospitals will be issued at a later date.)

A. Determining Required Level of Care.—If the committee believes that the patient no longer requires hospital care but could receive proper treatment in an extended care facility, it should determine whether there is a bed available to the patient in a participating extended care facility in the area (see C and E below). If there is, the committee should find that further stay in the hospital is not medically necessary.

If the committee determines that no bed is available to the patient in a participating extended care facility, it should find that continued stay in the hospital is medically necessary. The basis for the decision should be documented in the committee records. The committee will advise the attending physician that its decision is based on the lack of availability of a bed in a participating extended care facility; and that it is his responsibility to attempt on a continuing basis (with the assistance of the hospital's social worker,

etc.) to place his patient in a participating extended care facility as soon as a bed becomes available.

If the utilization review committee determines that the patient requires services other than inpatient hospital or extended care services (such as custodial, outpatient, or home health care), it should find, without regard to the availability of such kinds of care, that further inpatient hospital stay is not medically necessary. Covered inpatient hospital or extended care services should not be considered as an alternative to noncovered or noninstitutional services.

B. Home Health Care as an Alternative to Institutionalization.—A patient who needs either hospital or extended care services continually requires a level of care and a scope of services that can only be provided in an institutional setting. Only those institutions which meet the conditions of participation for hospitals and extended care facilities are qualified to provide them.

A patient who needs home health services requires a minimal level of services which does not call for the patient to be institutionalized. For example, an individual may only require a single service, such as physical therapy. A utilization review committee which finds that an individual only requires home health services should not recommend continued inpatient stay, even though the required services are not available to the individual because there is no agency in the community which can provide the services, or there is an agency but the individual has no home to which he can be discharged.

C. Location of Alternative Facilities.—A utilization review committee will consider what facilities are available in the community or local geographic area in deciding whether the patient can be cared for effectively elsewhere. It is not possible to define community or local geographic area with any precision. However, as a general rule, a community or local geographic area should not be defined in such a way as to require a patient to be taken away from his family and transported over great distances.

D. Patient's Financial Status and Personal Preference.—A utilization review committee should not take into account a patient's ability to pay for services or his coverage or lack of coverage under the health insurance program in deciding whether continued hospital stay is medically necessary.

A patient's preference for one extended care facility over another (such as a preference for a sectarian facility over a nonsectarian facility) should not be taken into account by the committee. If extended care facili-

ties are available but the patient's preferred facility is filled, the committee should find that further inpatient stay is not medically necessary.

E. Sources of Information on Available Participating Extended Care Facilities.—The Part A intermediary or the local social security office can supply the names and addresses of participating extended care facilities in the local area. Medical social workers, public health nurses, religious counselors, etc., can provide information about bed availability in such facilities.

290.4 Failure To Make Timely Review of Cases.—If the Social Security Administration determines, on the basis of information obtained by a State agency or by an intermediary during the course of its ongoing review of utilization practices, that a hospital has substantially failed to make timely review of long-stay cases, it may, in lieu of terminating its agreement with the hospital, decide that no payment may be made on behalf of patients for more than 20 consecutive days of inpatient hospital services. The Administration will determine the effective date of this limitation. It would apply to services provided to individuals admitted to the hospital after that date. Notice of the decision must be given to the hospital and to the public.

The limitation will be removed when it is determined that timely review of long-stay cases has been restored and there is reasonable assurance that the deficiency will not recur.

Appeals of Payment Determinations

295. HOSPITAL PROTEST OF PAYMENT DETERMINATION

The hospital and its intermediary should attempt to resolve mutually any differences involving payment that arise from the application of the cost formula or the amount payable in a specific case. No appeal is available for hospitals or other providers from intermediary payment determinations. However, provider complaints and protests will be considered in the Social Security Administration's review of the intermediary's application of the cost formula and its compliance with the other terms of its agreement with the Government.

296. BENEFICIARY PROTESTS AND APPEALS OF PAYMENT DETERMINATIONS

A. Hospital Insurance Program.—An individual dissatisfied with any determination of the amount of benefits payable on his behalf under hospital insurance may have his claim reconsidered by the Social Security Administration. If he is not satisfied with the reconsideration determination and the amount in controversy is \$100 or more, he may request a hearing by the Social Security Administration. If the amount in controversy is \$1,000 or more and he is dissatisfied with the hearing decision, the individual may initiate action for Federal court review of the claim.

B. Medical Insurance Program.—An individual dissatisfied with denial of a request for payment of medical insurance benefits, or with the amount of medical insurance benefits paid, or with the promptness with which his request for payment is acted upon is entitled to a review by, and if still dissatisfied, to a fair hearing by the medical insurance intermediary. Since the hospital is paid for the medical insurance services it furnishes by the same intermediary that makes hospital insurance payments to the hospital, this intermediary is responsible for the review and hearing under medical insurance.

A patient dissatisfied with a payment for the services of a hospital-based physician is entitled to a review by and, if still dissatisfied, to a fair hearing by the medical insurance intermediary to whom the bill for the physician's services was submitted for payment.

C. Patient protests concerning entitlement to health insurance benefits, or the denial; amount, or promptness of payment for items or services furnished by the hospital under hospital or medical insurance should be handled, if simply amenable to explanation or correction, by the hospital. If the patient wishes to protest the health insurance determination on his request for payment or the promptness of payment, he should be referred to his social security district office. The district office can offer assistance to the beneficiary in determining his appeal rights and can answer specific questions about the appeal procedures. The district office can also assist the individual in completing the necessary forms for requesting reconsideration or hearing.

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ADMISSION PROCEDURES

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Chapter III

ADMISSION PROCEDURES

300. SUMMARY OF ADMISSION PROCEDURES

The purpose of this section is to give a brief outline of routine handling of admissions. Detailed instructions on procedures as well as descriptions of special situations are given in subsequent sections.

The first step in preparing the Notice of Admission in inpatient cases is to ask the patient for his health insurance card. **It is very important that the claim number on this card be accurately recorded on the admission notice since the case cannot be processed if the number is missing or incorrect.**

If you cannot get the health insurance claim number from the patient, get in touch with the social security district office for help.

The second step is to ask the patient if he was an inpatient in any hospital or extended care facility during the prior 60 days. If he was, ask for additional information about the number of days of hospitalization he has had in the current spell of illness. This will indicate how many days of eligibility remain in this spell of illness. Your intermediary (or the Social Security Administration if you are dealing directly with the Government) will make any necessary additional verification of these prior stays.

The third step is to fill in the other items on the admission form, have the patient sign the form or the hospital's admission record (see §§ 270 ff.), and send the information to your intermediary or the social security office if you deal directly.

Your intermediary will check the Social Security Administration central record, then send you a reply giving the patient's remaining days of eligibility and deductible status so that you can prepare the billing form.

In outpatient cases you will go through the same steps of asking for the health insurance card to establish whether the patient is entitled under Part A and Part B, and to obtain the correct health insurance claim number. However, you will send the admission in-

formation to your intermediary at the same time you forward your billing. (See § 420.1 for completing admission items for outpatient hospital services.)

302. HEALTH INSURANCE CARD

The Social Security Administration maintains in Baltimore, Maryland, the records of all persons entitled to health insurance. After entitlement is established, each beneficiary is issued a health insurance card by the Social Security Administration (or in some cases by the Railroad Retirement Board) for use in obtaining hospital insurance benefits, medical insurance benefits, or both.

The health insurance claim number on the card is essential in locating the patient's record when a claim for benefit payment is made. **No admission notice or billing form should be forwarded without the correct claim number.** Exhibit 1 of this chapter shows the health insurance cards and briefly explains the numbering system as an aid in recognizing valid numbers.

The hospital should ask each patient who gives his age as 65 or more for his health insurance card to determine his health insurance entitlement status and obtain the correct health insurance claim number. When the hospital knows in advance of an impending stay by a 65 year-old patient, it should advise him to bring his health insurance card when admitted, and suggest that he get in touch with the social security district office if he does not have one. If a patient already in the hospital is within 3 months of age 65 and has not applied for hospital insurance entitlement, it will be helpful if he, or someone on his behalf, is advised to contact the district office. The hospital may wish to arrange with the district office to bring such cases routinely to its attention.

A health insurance card is acceptable without a signature. However, the patient should be asked to sign the card if he has not already done so.

302.1 Certificate of Social Insurance Award or Temporary Eligibility Notice.—An individual who has not yet received his health insurance card may present one of the following to indicate his health insurance entitlement status.

a. **Certificate of Social Insurance Award.**—Health insurance beneficiaries receive a Certificate of Social Insurance Award (see exhibit 1B) showing the health insurance claim number, dates of entitlement to Part A and Part B, and the following statement:

“This notice may be used if medicare services are needed before you receive your health insurance card.”

b. **Temporary Eligibility Notice.**—Where there is a need for immediate medical services, the social security district office may issue a temporary health insurance eligibility notice (see exhibit 1C) before a Certificate of Social Insurance Award or health insurance card is issued.

The patient's name and health insurance claim number on these notices should be entered on the admission notice. The intermediary will use this information for checking the Social Security Administration central record and for replying to the hospital about the patient's days of eligibility and deductible status.

304. NOTICE OF HOSPITAL (OR MEDICAL) INSURANCE UTILIZATION OR EXPLANATION OF BENEFITS

If the patient cannot furnish his health insurance card or one of the notices described in § 302.1 when admitted, he may have a utilization form which shows his claim number. Form SSA-1533, Notice of Hospital Insurance Utilization (see exhibit 2) is mailed to a beneficiary shortly after Part A inpatient hospital, extended care, or home health benefits have been paid on his behalf. Form SSA-1533A, Notice of Medical Insurance Utilization (see exhibit 3) is mailed to a beneficiary after payment of Part B home health benefits. An Explanation of Benefits is sent to a beneficiary by the Part B carrier after payment of a supplementary medical insurance claim. The beneficiary receives a utilization notice after payment on his behalf for Part A or Part B outpatient hospital services.

These forms, if current, may also indicate to the hospital the patient's remaining eligibility under hospital insurance, or deductible status under supplementary medical insurance. **However, an admission notice must always be sent in inpatient cases regardless of the currency of any of these forms.**

306. CONTACTS WITH SOCIAL SECURITY DISTRICT OFFICE TO OBTAIN HEALTH INSURANCE CLAIM NUMBERS

When a patient cannot furnish the health insurance claim number, the hospital may request it from the social security district office. Ordinarily, the social security office will have arranged with the hospital for handling these requests. If not, the hospital should get in touch with the office to make such arrangements.

The social security office can also help a beneficiary replace a lost or destroyed health insurance card.

306.1 Information Required by Social Security District Office.—If the patient's social security account number is available, the district office usually requires no additional information to locate the health insurance claim number or to determine that the patient has not established health insurance entitlement.

If the patient has ever been employed or self-employed, or sought employment, or filed Federal income tax returns, he should have a social security card. This card contains his social security account number which consists of 9 digits, 000-00-0000, but does not have the letter prefix or suffix which distinguishes the health insurance claim number. (See exhibit 1.)

A social security account number without a letter prefix or suffix is *not* sufficient for processing a claim.

If the account number is not available, the following information should be furnished.

a. The patient's name and statement as to whether or not he ever applied for social security monthly benefits, railroad retirement benefits, or for hospital insurance benefits;

b. If the patient says he applied, the name of the person on whose social security account the application was based, e.g., his own account or the account of a husband or a wife;

c. The full name of the patient's father, the maiden name of the patient's mother, and the patient's date and place of birth;

d. Patient's address.

If the hospital cannot give all the identifying information required from the beneficiary, it should furnish as much as it has to the social security district office.

306.2 The Social Security District Office Reply.—The social security office will furnish the health insurance claim number as soon as possible. If the claim number is not available, the office will inform the hospital of the action it is taking, i.e., that a claim

number has been requested from SSA central records, that it is developing an application, or that an application is pending.

If an application for hospital insurance benefits is taken as a result of the request to the district office for a claim number, or is pending when the hospital requests a claim number, the office will give the hospital the claim number when processing is completed. The hospital may then send the notice of admission information to the intermediary (or to the district office if the hospital deals directly with SSA).

308. HOSPITAL ADMISSION WHERE A HEALTH INSURANCE CLAIM NUMBER IS NOT AVAILABLE AND PATIENT'S CONDITION IS CRITICAL OR DISCHARGE IS NEAR

Occasionally a patient age 65 or older is admitted to a hospital in critical condition, a health insurance claim number is not available, and there is some question whether he has established health insurance entitlement. The normal procedures of contacting the social security office may not afford sufficient protection of the individual's benefit rights. In such cases, the hospital should have a Form SSA-18, Application for Hospital Insurance (or a comparable protective statement, see below) completed on the patient's behalf by an interested person, e.g., a relative who may be available.

If no interested person is available, the hospital administrator or his designee may complete the application. Only as much of the identifying information required in Items 1 through 5 on the form as is readily available should be completed. It is imperative, however, that the form show the patient's name and that it be signed.

The procedure may also be used where the patient is to be discharged shortly and his claim number is unavailable. In this situation, the application (or statement) may be completed either by the patient or by someone on his behalf if he is unable to do so.

The number of instances when this procedure will be used will be quite limited. Supplies of form SSA-18 will be made available by the social security office. Larger hospitals will wish to obtain a small supply. Smaller hospitals, however, may find it preferable to prepare a statement to be signed by the interested party which reads as follows:

"I hereby apply on behalf of _____
_____ for all benefits payable under
the Social Security Act."

The application or statement must be completed while the patient is alive. It is effective upon receipt by the Social Security Administration. Therefore, it should be submitted or mailed to the social security office on the same day it is executed. When it is mailed, the postmark date will serve to establish the effective filing date with SSA. The social security office will get in touch with the individual to obtain any additional information necessary to complete the application.

In the situations discussed above, a request for health insurance payment executed in accordance with § 271 would be appropriate.

309. INTERMEDIARY REQUESTS TO VERIFY PATIENT'S HEALTH INSURANCE CLAIM NUMBER

Where the name and claim number information on a notice of admission does not match the central record, the intermediary will request the hospital to verify the information. (In outpatient cases, the intermediary will verify the information on the outpatient billing form either with the hospital or the social security office.)

The hospital should first verify the name and number on the admission notice with the patient if he is still in the hospital, or, if he has been discharged, check its records. If the information submitted was incorrect, the hospital should send the corrected information to the intermediary.

If, however, the hospital finds that its information identifying the patient is the same as the information already submitted on the notice of admission (or outpatient billing form), it should contact the social security office for assistance. The hospital should inform that office that an admission notice was rejected because the name or number submitted did not match the Social Security Administration central record.

After investigation, the social security office will furnish the hospital with the correct name or number, or will confirm that the individual is not entitled to health insurance. The hospital should report this information to the intermediary.

310. NOTICE OF ADMISSION

When a patient 65 years or older is being admitted to the hospital for inpatient services, the hospital will complete the admission part of the inpatient hospital admission and billing forms.

There are two forms: SSA-1453, Inpatient Hospital Admission and Billing; and SSA-1485, Inpatient Psychiatric or Tuberculosis Hospital Admission and Bill-

ing. The bottom two copies of these forms are the admission copies. The top copies are retained for billing purposes, while the bottom copies may be detached and used in furnishing admission information to the intermediary.

Upon completion of the form furnish the notice of admission information to the intermediary (or to the appropriate Social Security Administration district office if the hospital deals with SSA). This information may be forwarded by mail, messenger, or telephone depending on the arrangements with the intermediary or the district office.

The admission notice should not be forwarded before the first date a patient is actually entitled to hospital insurance benefits. If a patient enters the hospital before the month he becomes age 65, the admission notice should not be sent before the first day of the month in which he becomes 65.

310.1 Completing Inpatient Hospital Notice of Admission, Form SSA-1453.—Use a typewriter for all entries on the forms, and show month, day, and year in 6-digit numbers, e.g., 07/01/66. (See exhibit 4 for a sample of the inpatient admission notice.)

Item 1. Patient's Name. Enter the patient's name. It should be the same as that shown on his health insurance card with the last name first.

Item 2. Health Insurance Claim Number. Enter the patient's health insurance claim number as shown on his health insurance card, certificate of award, utilization notice, temporary eligibility notice, or as reported by the social security office.

Item 3. Patient's Address. Enter the patient's mailing address.

Item 4. Date of Birth. Enter the patient's date of birth. If the date of birth is unknown, transmit the notice of admission without the date of birth. If only the year of birth is known, show that year. While the date of birth is useful as identification and should be shown when available, an admission notice will be processed without the date of birth.

Item 5. Sex. Enter "X" in the appropriate block.

Items 6 and 7. Hospital Identification. Enter the name and address of the hospital and the hospital's assigned health insurance provider number. This information may be preprinted on all copies of the hospital's supply of these forms.

Item 8. Medical Record Number. Make no entry unless the hospital is presently assigning such numbers for its own filing purposes.

Item 9. Attending Physician. Enter the name of the attending physician. Show his address only if

your intermediary requires that an address be shown.

Item 10. Date of This Admission. Enter the date of this admission. Enter the actual date of admission even where the effective date of entitlement is a later date. For example, where a patient entered a hospital on March 24, 1967, and will be entitled to hospital insurance on April 1, 1967, enter the actual admission date, 03/24/67. However, do not forward the Notice of Admission before the patient's entitlement date of April 1, 1967.

Item 11. Prior Stay Information. Enter the name and address of any hospital (including your own), or extended care facility, from which the patient says he was discharged as an inpatient within the last 60 days. If the patient has a Notice of Hospital Insurance Utilization showing a prior stay, give the dates shown. If the prior stay was in your hospital, enter "SAME" and the dates of the prior stay.

A recent prior admission or discharge may indicate whether the patient has limited or no eligibility in the current spell of illness, whether the \$40 inpatient or whole blood deductibles apply to this hospital stay, or whether the coinsurance provision will be in effect.

Inpatient benefits are related to a spell of illness and, once begun, a spell of illness cannot end until an individual has **not** been an inpatient of a hospital or extended care facility for 60 consecutive days beginning with the day of last discharge. An inpatient stay in a hospital or extended care facility continues a spell of illness and prevents the start of a new spell of illness with the current admission.

The information furnished by the hospital on the admission notice will be checked against the patient's central record and the intermediary's record. If further investigation is necessary, e.g., the date of prior discharge is not recorded on the patient's utilization record, or the prior-stay institution was a nonparticipating provider, the intermediary will verify the prior dates of stay.

Item 12. Payment Source. Check the appropriate box(es) to identify who will pay any charges that will not be paid for under the health insurance program. This item may be completed either at the time of admission or when billing. More than one source may be checked, if it applies. If the hospital will not bill anyone for expenses not reimbursable under the program, the item need not be completed.

When some or all of the charges are payable under a federally supported assistance program of the Social Security Act, identify the public agency in addition to checking the box. Enter the agency's name and address, and the patient's case number, if available.

The intermediary may find it necessary to forward a copy of the form to the public agency.

Item 13. Patient's Certification and Payment Request. Have the patient or his authorized representative read the statement on the form or the statement in the hospital admission record if the hospital uses the alternate signature procedure (see §§ 270 ff.). If the hospital obtains the signature on its own form, the signature line of the original of form SSA-1453 should be stamped to indicate that the "Patient's request for payment is on file." If the signature is obtained on form SSA-1453, it is sufficient if it is legible only on the original.

If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf; e.g., John J. Jones by Jack A. Smith. In certain situations, a hospital representative may sign on behalf of the patient. (See § 271 for who may file a payment request.)

Briefly explain why the patient himself did not sign the form and show the relationship of the signer to the patient. Retain the explanation in the hospital's file if the signature is obtained on the hospital's own record. If the signature is on form SSA-1453, the explanation should accompany or be included on the billing form.

The statement should be read to a patient who signs by mark. A signature by mark should be witnessed by a person who knows the patient. Enter the name and address of any person witnessing a signature by mark.

Item 14. Admitting Diagnosis. Enter the admitting diagnosis as furnished by the physician. List the primary condition first. Enter an "X" in the checkbox to indicate whether or not the condition was employment related. If the condition is known to be employment related, show the name and address of the employer. (See §§ 289 ff. for effects of workmen's compensation involvement.)

310.2 Completing Admission Information on Inpatient Psychiatric or Tuberculosis Hospital Admission and Billing, Form SSA-1485.—The items on the admission portion of the form SSA-1485 are like those for the inpatient form, SSA-1453, except for items 10, 11, and 12. These are designed to show the dates an individual was receiving active treatment or necessary inpatient psychiatric diagnostic services in a participating hospital meeting the special requirements for psychiatric or tuberculosis hospitals. They also call for the special information needed to determine whether an inpatient stay in the 90-day period

before the patient's entitlement to hospital insurance counts against the 90 days available to him in his first spell of illness. (See exhibit 5.)

Item 10. Admitted for Active Care. This is the date the patient was admitted for active treatment or for a medically necessary inpatient diagnostic study. This will ordinarily be the day on which the patient is admitted to the hospital (or qualifying distinct part of the hospital) which is equipped for such treatment or diagnostic services, even though the actual treatment or diagnostic procedures did not begin until a later date.

Item 11. Prior-Stay Information. Show the name and address of any hospital (including your own), or extended care facility, in which the patient received care during the last 60 days. See the explanation of the effect of prior stays under item 11 of the inpatient notice of admission in § 310.1 above.

Where the patient was in your hospital, but not in the part of the hospital which has been certified as meeting the definition of a psychiatric or tuberculosis hospital, show "this hospital—stay before admission to active care from (date) to (date)."

Item 12. Name and Address of Any Psychiatric or Tuberculosis Institution Which Furnished Inpatient Services at Any Time During the 90-Day Period Preceding Effective Date for Hospital Insurance. This is the name and address of any psychiatric or tuberculosis institution which furnished inpatient services in the 90-day period preceding the patient's effective date for hospital insurance entitlement. The effective date of the patient's entitlement to hospital insurance is shown on his health insurance card. If the institution named is your own hospital:

(a) If it is a stay in your hospital or part of your hospital which meets the definition of a psychiatric or tuberculosis hospital, show "this hospital—from (date) to (date)."

(b) If the stay was in that part of your hospital which does not meet the definition of a psychiatric or tuberculosis hospital, show "this hospital—not for active care from (date) to (date)."

315. CONTENTS OF INTERMEDIARY REPLY TO NOTICE OF ADMISSION

The reply to the notice of admission will be furnished by the intermediary to the hospital according to prior arrangements. If the hospital deals directly with the Social Security Administration, it will receive a form reply to the notice of admission from Bureau of Health Insurance, Direct Reimbursement. The contents of the reply will be based on the intermediary's

query of the SSA central record for eligibility information, and any necessary investigation of prior inpatient stays.

The "Report of Eligibility" part of the inpatient admission and billing forms (see exhibit 4) may be used as a reply to the admission notice, where it is received by the intermediary as part of the admission notice. Whether the reply is given by telephone, mail, or wire to the hospital, it contains eligibility information similar to the content of the "Report of Eligibility" part of the admission notice. An explanation of the eligibility information in the "Report of Eligibility" is outlined below:

A. *Effective Date—Hospital Insurance.* The month, day, and year of patient's entitlement to hospital insurance benefits (Part A) will be shown. If not entitled, the entry will so indicate.

B. *Effective Date—Medical Insurance.* This will show the month, day, and year of the patient's entitlement to medical insurance (Part B). The entry will so indicate if the patient is not entitled to Part B benefits.

C. *Hospital Days Remaining.* The number of inpatient days for which payment can be made in full will be shown in the "FULL" block. The number of inpatient days for which the patient is responsible for coinsurance payments will be shown in the "COINSURANCE" block.

D. *Medical Plan Deductible.* The status of this deductible will be indicated by a checkmark in the block designated "MET" or "NOT MET." If the deductible is not met, the amount remaining to be met will not be shown.

E. *Remaining Inpatient Deductible.* The dollar amount of the \$40 inpatient deductible yet to be met for the current spell of illness will be shown. Where it has been met, "NONE," will be entered.

F. *Pints Remaining—Blood Deductible.* This will show the number of pints of blood needed to satisfy the whole blood deductible for the current spell of illness. Where applicable, "NONE" will be shown.

G. *ECF Days Remaining.* For informational purposes, the number of inpatient extended care facility days available for the current spell of illness will be shown. Where applicable, "NONE" will be shown.

H. *HHA Visits Remaining—Hospital Insurance and Medical Insurance.* For informational purposes the number of home health visits remaining for hospital insurance will be shown. Medical insurance visits remaining will not be routinely shown in replying to hospital notices of admission.

I. *Psychiatric Days Remaining.* This information will be shown where the admitting hospital is a psychiatric hospital. It will show the number of days remaining toward the 190-day lifetime limitation on inpatient psychiatric services.

J. *Open Item Information.* The information in this block will be completed by the intermediary when verifying reports of open items (admissions recorded in SSA central records, but not closed out by processing of a bill).

Where there is an open item reported from the SSA central record to the intermediary or Bureau of Health Insurance, Direct Reimbursement, either the intermediary or Direct Reimbursement will contact the "open item" provider to verify the stay, the date of the prior discharge, and status of the bill. The intermediary will use this information in computing the remaining days of eligibility.

Remarks. Any necessary explanation of eligibility information will be shown. This will include corrections in the name or health insurance claim number the hospital reported. When changes of this sort are shown, the name and claim number information on the billing form should be changed accordingly.

If name and claim number information did not match, the intermediary will request the hospital to verify. See § 309 for the action to be taken by the hospital.

The hospital may also be requested to verify reports of death shown in the patient's central record.

320. RETROACTIVE ENTITLEMENT

When an application for social security benefits is filed by a person over 65 years of age, he may inform the social security office that he received hospital services in the retroactive period of up to 12 months for which he may be entitled to benefits. Payment for the hospital services received in this period is possible (see § 120). The social security office will tell the individual to get in touch with the hospital. In these cases, follow the notice of admission procedure to obtain a report of eligibility from your intermediary before billing. If the patient had paid the hospital, the hospital should refund the appropriate amount.

325. INITIATING NOTICES OF ADMISSION WHERE NO PAYMENT WILL BE MADE

Section 450 explains that hospitals are to submit inpatient billing forms even when benefits are exhausted or are not payable for some other reason. In most such cases, notices of admission will have been initiated

as a normal course of hospital procedure to determine the patient's eligibility. However, there will be some situations where, at admission, the individual tells you that benefits have been exhausted in the current spell of illness, or he presents a Notice of Hospital Insurance Utilization which indicates this. The hospital should nevertheless initiate a notice of admission. This notice will serve to verify the information and assure that the patient has in fact no remaining eligibility.

The notice of admission is also essential for processing the billing form to be submitted in accordance with § 450.

Notices of admission should also be initiated where no payments can be made because of the following: Workmen's compensation paid or can be expected to pay the entire bill; services are not covered; the inpatient deductible is not met; the inpatient psychiatric and tuberculosis restriction (§ 217) fully reduces the inpatient benefit days available from 90 to none; payment will be made by a National Institutes of Health grant; or, the patient has refused to request payment.

Where the patient refuses to request payment and does not furnish his health insurance claim number, the hospital should attempt to get the claim number from the social security office. (See § 306.1 for the information that office needs to locate the claim number.)

330. NOTICES OF ADMISSION FOR EMERGENCY SERVICES IN NONPARTICIPATING HOSPITALS

Nonparticipating hospitals will use Form SSA-1453, Inpatient Hospital Admission and Billing as a notice of admission and to bill for covered emergency services. (Use Form SSA-1483, Outpatient Hospital Billing, for emergency outpatient services.) Where a patient is admitted for emergency services (see § 201.1), the admis-

sion portion of form SSA-1453 should be completed, and the bottom two copies detached and sent to the social security district office. Items 1 through 14 of the form are to be completed according to § 310.1. The words "EMERGENCY ADMISSION" should be typed, or printed with a ball point pen, in the right-hand portion of Item 12 (Payment Source for Charges to Patient) of the form.

The district office will transmit the admission notice to Social Security Administration central records. (If the hospital has not been assigned an identification number as a provider qualified to furnish emergency services, the district office will request the SSA regional office to determine the hospital's status and assign an emergency provider number if it qualifies.) A reply to the admission notice giving the patient's eligibility status will be mailed directly to the hospital by the Bureau of Health Insurance, Direct Reimbursement Branch.

When claiming payment, the hospital completes the remainder of form SSA-1453 and sends it, with a copy of the eligibility reply and supporting documentation (see §§ 202 ff.), to the social security district office.

399. EXHIBITS

Exhibit 1A. Health Insurance Cards and Claim Numbers.

Exhibit 1B. Certificate of Social Insurance Award.

Exhibit 1C. Temporary Notice of Eligibility.

Exhibit 2. Notice of Hospital Insurance Utilization (Form SSA-1533).

Exhibit 3. Notice of Medical Insurance Utilization (Form SSA-1533A).

Exhibit 4. Inpatient Hospital Admission and Billing (Admission Copy)—Form SSA-1453.

Exhibit 5. Inpatient Psychiatric or Tuberculosis Hospital Admission and Billing (Admission Copy)—Form SSA-1485.

EXHIBIT I-A

HEALTH INSURANCE CARDS

Health Insurance	
SOCIAL SECURITY ACT	
NAME OF BENEFICIARY JANE Q. DOE	
CLAIM NUMBER 000-00-0000B	SEX FEMALE
IS ENTITLED TO HOSPITAL INSURANCE 7-1-66 MEDICAL INSURANCE 7-1-66	
SIGN HERE <input type="checkbox"/>	

Front

Health Insurance	
RAILROAD RETIREMENT BOARD	
NAME OF BENEFICIARY JOHN C. DOE	
CLAIM NUMBER A-000-00-0000	SEX MALE
IS ENTITLED TO HOSPITAL INSURANCE 7-1-66 MEDICAL INSURANCE 7-1-66	
SIGN HERE <input type="checkbox"/>	

Front

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical or health services under "Medicare."
3. Get in touch with your social security office if you have questions about your rights under "Medicare."
4. Your card is good wherever you live in the United States.

WARNING: Issued for the sole use of the holder designated hereon. Intentional misuse of this card is unlawful and will make the offender liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT.
IF FOUND DROP IN NEAREST U.S. MAIL BOX.

Return To: SOCIAL SECURITY ADMINISTRATION
Baltimore, Maryland 21235

FORM SSA-1966 (7-66)

Back

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical or health services under "Medicare".
3. Get in touch with your Railroad Retirement Board office if you have questions about your rights under "Medicare."
4. Your card is good wherever you live in the United States. For benefits in Canada, write to the Railroad Retirement Board.

WARNING: Issued for the sole use of the holder designated hereon. Intentional misuse of this card is unlawful and will make the offender liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT.
IF FOUND DROP IN NEAREST U.S. MAIL BOX.

Return to: RAILROAD RETIREMENT BOARD
844 Rush Street, Chicago, Illinois 60611

Form G-43 (2-66)

Back

HEALTH INSURANCE CLAIM NUMBERS

Most HI claim numbers are 9 digits with a letter or letter and numeral suffix; e.g., 000-00-0000B or B1. They may also be 6-or-9-digit numbers with lettered prefixes; e.g., A000000, A-000-00-0000; or WD-000000, WD-000-00-0000. Numbers with one or more letter prefixes identify Railroad Retirement Board annuitants.

Possible suffixes are:

A, B, B1, B2, B3, B4, B5, B6, or B9

C1, C2, C3, C4, C5, C6, C7, C8, or C9

D, D1, D2, D3, D4, D5, D6, or D7

E, E1, E2, or E3

F1, F2, F3, F4, F5, F6, F7, or F8

HB, HB1, HB2, HB3, HB4, HB5, HB6, or HB9

HC1, HC2, HC3, HC4, HC5, HC6, HC7, HC8, or HC9

J1, J2, J3, J4 (For subscripts "3" and "4" there can be no entitlement to hospital insurance benefits.

K1, K2, K3, K4 Supplementary medical insurance entitlement may exist for all J and K suffixes.)

M, M1, and T (Suffix letter "T" indicates entitlement to hospital or hospital and medical insurance; letters M and M1 indicate that the patient is eligible for supplementary medical insurance benefits but not for hospital insurance benefits.)

When the status of a beneficiary changes, it is possible for the suffix of his claim number to change.

EXHIBIT 1-B

DISTRICT OFFICE

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

CLAIM NUMBER

Certificate of Social Insurance Award

PAYMENT CENTER:

DATE:



THIS IS TO CERTIFY THAT THE PERSON(S) NAMED BELOW BECAME ENTITLED TO THE INSURANCE BENEFITS SHOWN, PAYABLE UNDER TITLE II OF THE SOCIAL SECURITY ACT.

NAME AND ADDRESS OF PAYEE AS THE CLAIMANT
OR AS REPRESENTATIVE OF THE CLAIMANT

DATE OF
ENTITLEMENT

MONTHLY
BENEFIT

AMOUNT OF
FIRST CHECK

TYPE OF BENEFIT:

The right to receive social security benefits carries with it certain responsibilities. They are explained in the enclosed booklet. Read this booklet carefully. Be sure that you understand clearly what you can expect by way of benefits, and what is to be expected of you.

NOTICE: If you believe that this determination is not correct, you may request that your case be reexamined. If you want this reconsideration, you must request it not later than 6 months from the date of this notice. You may make any such request through your social security office. If additional evidence is available, you should submit it with your request.

ROBERT M. BALL
COMMISSIONER OF SOCIAL SECURITY

EXHIBIT 1-C

TEMPORARY NOTICE OF ELIGIBILITY

District Office Address:

Date:

Dear _____ :

Based on the information you have given to the Social Security Administration you will be eligible for hospital insurance benefits beginning (mo.) _____ (yr.) _____ and for supplementary medical insurance benefits beginning (mo.) _____ (yr.) _____. Your eligibility will continue for 60 days from the date shown at the top of this notice unless you are notified otherwise during the 60-day period.

To obtain medical services before you receive your card, show this letter to your hospital or doctor but keep the letter with you. This temporary notice of eligibility is to be used only by the person to whom it is addressed. Misuse is unlawful and will make the offender liable to a penalty.

This letter should be destroyed as soon as you receive your health insurance card or other notice concerning your eligibility.

Sincerely yours,

Robert M. Ball
Commissioner of Social Security

IMPORTANT

When services are provided on the basis of this notice, all bills or correspondence with an intermediary or the Social Security Administration should show the patient's social security claim number.

EXHIBIT 2

NOTICE OF HOSPITAL INSURANCE UTILIZATION, SSA-1533

FORM SSA-1533 (5-66)



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

NOTICE OF HOSPITAL INSURANCE UTILIZATION

NAME AND ADDRESS OF THE BENEFICIARY
OR REPRESENTATIVE OF THE BENEFICIARY

DATE:

HEALTH INSURANCE CLAIM NUMBER:

The bill for HOSPITAL INSURANCE services described below was recently submitted under your health insurance claim number and recorded to your account.

TYPE OF SERVICES	DATES COVERED BY BILL		NUMBER OF HOME HEALTH VISITS INCLUDED
	FROM	TO	

Institution or agency
providing services

Office which handled
your claim

For each spell of illness, your HOSPITAL INSURANCE under Medicare pays the costs of all covered services, with certain exceptions. These are the exceptions for this bill:

RECORD OF ADDITIONAL BENEFITS AVAILABLE

As of the date of this notice, your record of inpatient hospital and extended care benefits for the spell of illness involved and your record of home health benefits is as follows:

INPATIENT HOSPITAL DAYS			EXTENDED CARE FACILITY DAYS			HOME HEALTH VISITS		
USED THIS BILL	USED TO DATE	REMAINING	USED THIS BILL	USED TO DATE	REMAINING	USED THIS BILL	USED TO DATE	REMAINING

If you have to use HOSPITAL INSURANCE services again, please take this latest notice with you and show it, along with your Health Insurance card, to the agency or institution furnishing the services.

Robert M. Ball
Robert M. Ball
Commissioner of Social Security

PLEASE READ THE OTHER SIDE OF THIS NOTICE FOR IMPORTANT INFORMATION.

EXHIBIT 3

NOTICE OF MEDICAL INSURANCE UTILIZATION, SSA-1533A

FORM SSA-1533A (6-66)



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

NOTICE OF MEDICAL INSURANCE UTILIZATION

NAME AND ADDRESS OF THE BENEFICIARY
OR REPRESENTATIVE OF THE BENEFICIARY

DATE:

HEALTH INSURANCE CLAIM NUMBER:

The bill for MEDICAL INSURANCE services described below was recently submitted under your health insurance claim number and recorded to your account.

TYPE OF SERVICES	DATES COVERED BY BILL		NUMBER OF HOME HEALTH VISITS INCLUDED
	FROM	TO	

Institution or agency
furnishing services }

Office which handled
your claim }

Each year, as soon as your covered medical expenses go over \$50, your MEDICAL INSURANCE will pay 80 percent of the reasonable costs or charges for all additional covered services for the rest of the year. The computation of MEDICAL INSURANCE benefits for this bill is shown below.

TOTAL COVERED CHARGES	AMOUNT TOWARD \$50 DEDUCTIBLE	20% PAYABLE BY BENEFICIARY	TOTAL PAYABLE BY BENEFICIARY

STATUS OF MEDICAL INSURANCE RECORD

As of the date of this notice, the status of your MEDICAL INSURANCE record is as follows:

Robert M. Ball

Robert M. Ball
Commissioner of Social Security

PLEASE READ THE OTHER SIDE OF THIS NOTICE FOR IMPORTANT INFORMATION.

EXHIBIT 4

THE ADMISSION COPY OF THE INPATIENT HOSPITAL ADMISSION AND BILLING FORM



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

INPATIENT HOSPITAL ADMISSION AND BILLING
HOSPITAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

Form Approved
Budget Bureau
No. 72-R734

1. PATIENT'S LAST NAME		FIRST NAME		MI	2. HEALTH INSURANCE CLAIM NUMBER	
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)					4. DATE OF BIRTH	5. SEX <input type="checkbox"/> M <input type="checkbox"/> F
6. HOSPITAL NAME AND ADDRESS			7. PROVIDER NO.		9. NAME AND ADDRESS OF ATTENDING PHYSICIAN	
			8. MEDICAL RECORD NO.			
10. DATE OF THIS ADMISSION		11. NAME AND ADDRESS OF ANY INSTITUTION FROM WHICH DISCHARGED DURING LAST 60 DAYS (If this hospital, give dates of stay)				
12. PAYMENT SOURCE FOR CHARGES TO PATIENT						
<input type="checkbox"/> SELF OR FAMILY <input type="checkbox"/> BLUE CROSS <input type="checkbox"/> PUBLIC AGENCY <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> BLUE SHIELD (Give name) <input type="checkbox"/> EMPLOYER OR UNION <input type="checkbox"/> OTHER (Explain)						
13. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.						
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)						DATE
14. ADMITTING DIAGNOSIS				EMPLOYMENT RELATED	<input type="checkbox"/> YES <input type="checkbox"/> NO If yes, give name and address of employer	

REPORT OF ELIGIBILITY

A. Effective Date - Hospital Insurance			J. Open Item Information 1. Intermediary
B. Effective Date - Medical Insurance			
C. Hospital Days Remaining	Full	Coinsurance	
D. Medical Plan Deductible	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	
E. Remaining inpatient Deductible \$			
F. Pints Remaining Blood Deductible			
G. ECF Days Remaining			
H. HHA Visits remaining	Hospital Insurance	Medical Insurance	
I. Psychiatric Days Remaining			
Remarks			
			3. Date Admitted
			4. Date Discharged
			Intermediary Approval

FORM SSA-1453 (4-68)

ADMISSION COPY

EXHIBIT 5

THE ADMISSION COPY OF THE INPATIENT PSYCHIATRIC OR TUBERCULOSIS HOSPITAL
ADMISSION AND BILLING FORMDEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATIONINPATIENT PSYCHIATRIC OR TUBERCULOSIS HOSPITAL ADMISSION AND BILLING
HOSPITAL INSURANCE BENEFITS - SOCIAL SECURITY ACTForm Approved.
Budget Bureau
No. 72-R732

1. PATIENT'S LAST NAME		FIRST NAME	MI	2. HEALTH INSURANCE CLAIM NUMBER	
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)				4. DATE OF BIRTH	5. SEX <input type="checkbox"/> M <input type="checkbox"/> F
6. HOSPITAL NAME AND ADDRESS		7. PROVIDER NO.		9. NAME AND ADDRESS OF ATTENDING PHYSICIAN	
		8. MEDICAL RECORD NO.			
10. ADMITTED TO ACTIVE CARE		11. NAME AND ADDRESS OF ANY INSTITUTION (including this institution) IN WHICH PATIENT RECEIVED INPATIENT CARE DURING LAST 60 DAYS (If this hospital, give dates of stay)			
12. NAME AND ADDRESS OF ANY PSYCHIATRIC OR TUBERCULOSIS INSTITUTION WHICH FURNISHED INPATIENT SERVICES AT ANY TIME DURING 90 DAY PERIOD PRECEDING EFFECTIVE DATE FOR HOSPITAL INSURANCE (If this hospital, give dates of stay)					
13. PAYMENT SOURCE FOR CHARGES TO PATIENT					
<input type="checkbox"/> SELF OR FAMILY <input type="checkbox"/> BLUE CROSS <input type="checkbox"/> PUBLIC AGENCY <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> BLUE SHIELD (Give name) <input type="checkbox"/> EMPLOYER OR UNION <input type="checkbox"/> OTHER (Explain)					
14. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.					
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)					DATE
15. ADMITTING OR CURRENT DIAGNOSIS EMPLOYMENT RELATED <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, give name and address of employer.)					

REPORT OF ELIGIBILITY

A. Effective Date - Hospital Insurance		J. Open Item Information 1. Intermediary	
B. Effective Date - Medical Insurance			
C. Hospital Days Remaining	Full Coinsurance		
D. Medical Plan Deductible	<input type="checkbox"/> Met <input type="checkbox"/> Not Met		
E. Remaining Inpatient Deductible		2. Provider	
F. Pints Remaining Blood Deductible			
G. ECF Days Remaining			
H. HHA Visits Remaining	Hospital Insurance Medical Insurance		
I. Psychiatric Days Remaining		3. Date Admitted	
Remarks			
		4. Date Discharged	

INTERMEDIARY APPROVAL

DATE

FORM SSA-1485 (4-88)

ADMISSION COPY

Chapter IV

BILLING PROCEDURES

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DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

INPATIENT HOSPITAL ADMISSION AND BILLING
HOSPITAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

Form Approved
Budget Bureau
No. 72-R734

1. PATIENT'S LAST NAME			FIRST NAME		MI	2. HEALTH INSURANCE CLAIM NUMBER		
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)						4. DATE OF BIRTH		5. SEX <input type="checkbox"/> M <input type="checkbox"/> F
6. HOSPITAL NAME AND ADDRESS				7. PROVIDER NO.		9. NAME AND ADDRESS OF ATTENDING PHYSICIAN		
				8. MEDICAL RECORD NO.				
10. DATE OF THIS ADMISSION			11. NAME AND ADDRESS OF ANY INSTITUTION FROM WHICH DISCHARGED DURING LAST 60 DAYS (If this hospital, give dates of stay)					
12. PAYMENT SOURCE FOR CHARGES TO PATIENT <input type="checkbox"/> SELF OR FAMILY <input type="checkbox"/> BLUE CROSS BLUE SHIELD <input type="checkbox"/> PUBLIC AGENCY (Give name) <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> EMPLOYER OR UNION <input type="checkbox"/> OTHER (Explain)								
13. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.								
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)								DATE
14. ADMITTING DIAGNOSIS				EMPLOYMENT RELATED		<input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, give name and address of employer
15. DISCHARGE DIAGNOSES OR CURRENT DIAGNOSES (Primary illness and secondary or complicating illnesses)								Do not use this space
16. SURGICAL PROCEDURES (Related to primary illness and other—Show date of each)								
17. STATEMENT OF SERVICES RENDERED								
ACCOMMODATION			DAYS	RATE	TOTAL CHARGES		NON-COVERED CHARGES	
A. 1-Bed					\$		\$	
B. 2-3-4 Bed								
C. 5 or more Beds								
D. Intensive Care								
E. Self Care								
F. WHOLE BLOOD	PINTS FURNISHED	NOT REPLACED	CHARGE PER PINT					
G. Operating Room								
H. Pharmacy								
I. Laboratory								
J. Radiology								
K. Medical, Surgical and Central Supplies								
L. Anesthesia								
M. Inhalation Therapy								
N. Other (Describe)								
O. TOTALS					\$		\$	
P. Inpatient Deductible								
Q. Blood deductible			Pts. @					
R. Coinsurance								
S. TOTAL DEDUCTIONS								
I certify that the required physician's certification and recertifications are on file.								
26. SIGNATURE OF HOSPITAL REPRESENTATIVE					DATE FORWARDED		27. APPROVED BY	
							DATE	
18. STATEMENT COVERS PERIOD FROM TO 19. TOTAL DAYS								
20. DATE GUARANTEE OF PMT. OR UR NOTICE RECEIVED					21. DATE BENEFITS EXHAUSTED			
22. <input type="checkbox"/> DISCHARGED <input type="checkbox"/> DIED <input type="checkbox"/> STILL PATIENT					23. DATE DISCHARGED OR DIED			
24. COMPUTATION OF INTERIM PAYMENT								
Reimbursement Amount \$								
FOR INTERMEDIARY USE								
25. VERIFIED PRIOR STAY DATES FROM TO					PROVIDER NO.			
<input type="checkbox"/> NONE								
26. SIGNATURE OF HOSPITAL REPRESENTATIVE					DATE FORWARDED		27. APPROVED BY	
							DATE	

FORM SSA-1453 (4-66)

400. BILLING PROCEDURES—GENERAL

The forms used by hospitals for billing are:

SSA-1453—Inpatient Hospital Admission and Billing, is used to bill for inpatient services in a participating hospital unless the hospital meets the special qualifications for a psychiatric or tuberculosis hospital described in §§ 203–205. If inpatient care is given for a psychiatric or tubercular condition in a general hospital the form SSA-1453 is used.

SSA-1485—Inpatient Psychiatric or Tuberculosis Hospital Admission and Billing, is used by hospitals that meet the special requirements for participation as a psychiatric or tuberculosis hospital.

SSA-1483—Outpatient Hospital Billing, is used to bill for outpatient services whether such services are covered under hospital (Part A) or medical (Part B) insurance. Where a psychiatric or tuberculosis hospital maintains an outpatient department, its services will likewise be billed on form SSA-1483. If a hospital maintains an ambulance service, and the use of an ambulance met the requirements described in § 240.4, the ambulance is billed on form SSA-1483.

SSA-1554—Provider Billing for Patient Services by Physicians, is used if the hospital is authorized by a physician to bill on his behalf.

SSA-1484—Explanation of Accommodation Furnished, is used if an accommodation other than two, three, or four beds was furnished.

If a hospital maintains a home health services department, or a wing that qualifies as an extended care facility, billing for the services is made on Form SSA-1487, Home Health Agency Report and Billing, or SSA-1478, Extended Care Admission and Billing, respectively. Instructions for the completion of these forms are given in the home health agency and extended care facility manuals.

Inpatient Admission After Outpatient Services. Sometimes a patient is admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient before midnight of the day after the day outpatient services were rendered, all services are considered inpatient services for billing purposes. The day of formal admission as an inpatient will be considered as the first day of inpatient hospital services.

Charges Not Exceeding Deductibles. A billing form should be submitted even where the patient is responsible for a deductible which covers the entire amount of the hospital charges. This is required both for inpatient and outpatient situations.

Leave of Absence. It is not necessary to submit a new admission and billing each time the patient has a leave of absence. Instead, the hospital may bill for covered days, excluding the leave of absence, using the procedure described under Item 19, Total Days, of the SSA-1453, or Item 20, Total Days, SSA-1485. See also Items 22 and 24 of the SSA-1453 and SSA-1485, respectively, for billing leaves of absence in excess of 60 days.

Repeated Admissions and Discharges. Sometimes the patient's condition requires that he return at regular intervals to the hospital, e.g., he must be readmitted each week for blood transfusions. This case can be handled as a leave of absence. This procedure should only be used where admissions are predictable on a recurring basis, and where there is a brief interval between discharge and readmission. The procedure for billing these cases is described under Item 19, Total Days, of the SSA-1453, and Item 20, Total Days, of the SSA-1485.

Part B Entitlement Only. Do not submit an inpatient billing form where the patient has Part B only, even if an admission was previously forwarded.

402. INPATIENT HOSPITAL ADMISSION AND BILLING (FORM SSA-1453)

This form serves two purposes. It is used to report the admission of a patient who is eligible for hospital insurance so that the Social Security Administration and the hospital's intermediary can determine how many benefit days are available. It is also used to bill the intermediary for the payment due the hospital for the services rendered.

The bottom two copies of the form can be used to report the admission. (The procedures for reporting admissions are described in the Admission Procedures Chapter.) The hospital fills out items 1 through 14 of all copies of the form, **detaches the bottom two copies**, and notifies the intermediary in accordance with its usual procedures. (If the two copies allotted for admission notification are not used for this purpose, they may be destroyed.)

The instructions for using the intermediary's Report of Eligibility to determine the number of days for which payment can be made and any deductibles for which the patient is responsible are contained in § 315.

Items 15 through 26 of the billing form should be completed at the time the bill is rendered. The bill may be rendered at the time the patient is discharged or after his benefits are exhausted. It also may be submitted on an interim basis.

A billing form should also be submitted even though no program payment can be made—

- a. for periods after benefits are exhausted;
- b. when services are not covered;
- c. for the period after a utilization review finding that services are not medically necessary;
- d. when services are paid for, or can be expected to be paid for, by workmen's compensation;
- e. when services are paid for, or will be paid for by a National Institutes of Health grant;
- f. when the patient or his representative refuses to request that payment be made on his behalf;
- g. when the physician refuses to certify for a reason other than lack of medical necessity.

Such bills enable the Social Security Administration and the intermediary to maintain correct current records of deductibles and days available. It is not necessary to complete all the items on a form when there are no covered days.

See § 450 for the procedures for completing and submitting this kind of bill.

A hospital bill is also required when the deductible covers the entire amount of the hospital charges. A full bill is completed in these cases.

402.1 Completion of Billing Items on the Form SSA-1453.—

Item 15. Current or Discharge Diagnoses. Enter here all of the diagnoses shown on the face sheet or discharge sheet of the patient's hospital record which relate to the condition requiring the current hospitalization. The primary diagnosis should appear first. This is the diagnosis of the illness or condition which was the primary reason for the patient's hospitalization. Identify this primary diagnosis by writing the word "primary" in parentheses. Any remaining diagnoses should be listed in the same order in which they appear on the face sheet or discharge sheet. The diagnosis should be shown in accordance with recognized nomenclature, e.g., "Current Medical Terminology," or "Standard Nomenclature of Diseases and Operations."

Item 16. Surgical Procedures. Surgical procedures should be specified in detail using recognized nomenclature such as that used in "Current Medical Terminology," "Standard Nomenclature of Diseases and Operations," etc. For the purposes of this form, surgery includes incision, excision, amputation, introduction, endoscopy, repair, destructions, suture, and manipulations.

Enter the name of the procedures, if any, shown on the face sheet or discharge sheet of the patient's hospital record which were performed during the period covered by the bill. Show the dates of each operation or endoscopic procedure listed. List first those procedures related to the primary diagnosis. List all other operation and endoscopic procedures in the same order as is shown on the face sheet or discharge sheet.

Item 17. Statement of Services. Show all charges for the period covered by the current billing for each of the departments. Where your hospital has more departments than shown on the form, combine the charges, where appropriate, for the purpose of completing the form. Where charges for a department not listed on the form are applied to one of the departments listed, all bills submitted should apply the same charges consistently to the same departments.

For instance, if Recovery Room is applied to Line G—Operating Room, this should be done on a consistent basis, and should not be listed on Line N—Other—on any bills submitted. Where there is insufficient space to describe all the services performed in N, Other, it is permissible to combine all other charges. Continuation sheet attachments for charges are not to be used. However, if it is necessary to explain a particular item, this may be done on an attachment.

Machine-Produced Ledger Sheets.—Where the hospital wishes to submit machine-produced ledger sheets in lieu of the detailed completion of the Statement of Services item, it may do so if it has been following this practice for other insurance plans. The bill submitted by the hospital should contain departmental totals or subtotals. Hotel-type billings which summarize by day but not by department are not acceptable. Where the days, rate, and type of accommodation are not clear from the machine bill attachment, the hospital will make the accommodation entries. Also, unless blood furnished, replaced, and charge per pint is shown on the attachment, the hospital should complete Line F, Whole Blood.

Charges for services which are not covered should be fully identified either on the ledger sheet attached or in the "Noncovered Charges" column, unless such charges are routinely billed to all patients per discussion in **Total and Noncovered Charges**, below.

Any attachments, whether a machine bill or an explanation, should show the patient's name and health insurance claim number and the hospital's name and address.

Showing Discounted Charges. Credit or minus entries should not be shown on the billing form.

Where the hospital gives a discount to some patients, it can show charges in one of two ways. The charges can be shown as the full, undiscounted charge if full undiscounted charge data is accumulated for all patients for the purposes of the final cost reimbursement. The charges for the individual departments on the billing form should be shown as the discounted charges if the hospital, for the purposes of the final cost reimbursement, accumulates charges for all patients at the discounted rate.

Total and Noncovered Charges. In the **Total Charge** column the total charge for all services, covered and noncovered, will generally be shown. However, see Item 17A for the entries to be made when a patient is furnished private accommodations neither for medical reasons nor at his request, and the excess over semiprivate accommodations will not be charged to him; and see Item 17 G-O for the rules for entries when items or services are furnished which are more expensive or in excess of those covered by the program.

In the **Noncovered Charges** column, enter the amount of any noncovered charge **except** where the noncovered charge is routinely billed to medicare and nonmedicare patients alike. For instance, if it is the hospital's practice to bill nonmedicare patients for laboratory services which include the pathologist services as an integral part of the laboratory charge, the hospital should show the total laboratory charge, including the pathologist's component, in the Total Charges column **without breaking out the physician's component in the Noncovered Charge column.** (This does not preclude, of course, Part B billing by the hospital on behalf of the pathologist or by the pathologist on his own behalf, for services to the patient.)

Of course, if the hospital bills patients for laboratory services which do not include the physician's component, the physician's component would not be shown in Total Charges. The purpose of this method of reporting is to maintain the integrity of the ratio of costs to charges for the final cost reimbursement settlement, which requires a uniform accounting report for medicare and nonmedicare patients.

Note, however, that noncovered charges cannot be applied to the deductible. See the explanation for Line P, Inpatient Deductible.

Where a bill is submitted for a period including both covered and noncovered days (e.g., benefits exhausted during billing period), the charges for noncovered days are listed under noncovered charges. Where a

billing form covers only noncovered days, only Line O, Totals, need be completed. See § 450 on submitting bills for noncovered days.

Items A-E. Accommodation. See § 210.1 for an explanation of the rules governing when other than semiprivate accommodations are furnished.

Accommodation days should always be in terms of whole rather than fractional days. The accommodation days should not include the day of discharge, even where the discharge was late.

However, where the hospital normally makes an extra charge for a late discharge it should enter the extra charge in Total Charges, though the extra or fractional day which the charge represents should not be entered in the Days item. Where this charge was made because the patient remained in the hospital after checkout time for his own convenience, the charge may be made to the patient and should be entered in the Noncovered column as a noncovered charge. However, where a patient's stay beyond the checkout hour is occasioned by his medical condition, e.g., a bedridden patient awaiting transfer to his home or to an extended care facility, the services furnished by the hospital are covered charges.

Ancillary charges for day of discharge, death, or the day on which a leave of absence begins, should be shown in the proper department.

Where the patient is discharged on his first day of entitlement, it is permissible to submit a billing form with no accommodation charge, but with ancillary charges shown in Lines F through N.

Where some of the days cannot be paid for because benefits were exhausted before discharge or death, show the charges for days after benefits were exhausted under noncovered charges.

Where more than one rate has been used for a given type of accommodation, one of the unused accommodation lines may be relettered and used to show the entry.

Example: Patient spends 10 days in a two-bed room at \$25 per day and is then moved to a four-bed room at \$22 per day. Line C, which was not used, may be relettered B and used to show the second accommodation.

A. One bed. Where a patient needed a private room for medical reasons, complete and attach one copy of form SSA-1484 to explain the medical necessity. Enter the customary charge for a one-bed accommodation in the "Rate" column and complete the "Total Charges" column.

If the patient was in a one-bed accommodation for other than medical reasons, payment cannot be made for more than the cost of semiprivate accommodations.

(The completion of Form SSA-1484, Explanation of Accommodation Furnished, is not necessary in this case.)

1. If the patient requested a private room, the patient may be charged the difference between the private room charges and the most prevalent semiprivate room charges at the time of admission. If the hospital will charge him the difference, complete Item 17A showing the days, rate, and total charges for the private room accommodations.

In the Noncovered Charges column, show the difference between the private room charges and the most prevalent semiprivate room charges at the time of admission. (If the hospital does not charge the patient, complete Item 17B as in 2 below.)

2. If the patient did not request a private room, no charge may be made to him. In such a case, enter the most prevalent semiprivate rate, and the charges in the Total Charges column of Item 17B. No entry should be made in the Noncovered Charges column.

(See § 412.2, Item 6, for the method of figuring the most prevalent semiprivate rate. When the hospital is one which has only private accommodations, the most prevalent semiprivate accommodation rate is not applicable. In such a case, the hospital will use the equivalent semiprivate rate established by the intermediary in place of the most prevalent semiprivate rate (see § 210.1B.)

B. Two-, three-, or four-bed. If the patient occupies semiprivate accommodations (two-, three-, or four-bed room) show the number of days and the actual daily rate for the accommodations.

C. Five or more beds. Under the hospital insurance program, payment is ordinarily made for semiprivate accommodations (two-, three-, or four-bed room). If the patient is assigned to a room with five or more beds, the hospital should complete Form SSA-1484, Explanation of Accommodation Furnished, explaining the reasons for this accommodation. Two copies of the form should be prepared and attached to the billing form where the patient did not request the accommodation. Where the patient requested the accommodation, only one copy of the SSA-1484 is required for attachment to the billing form. (See § 412 for instructions on use of form SSA-1484 and completion of items.)

Where the patient requested a five or more bed assignment, or the reason for assignment is one that the intermediary can approve, the reimbursement will be made for the reasonable cost of the actual accommodation furnished. However, where the ward accommo-

dation was provided **not** at the patient's request, nor for a reason which the intermediary can approve, payment will be made, at the end of the year settlement, on the basis of the reasonable cost of semiprivate accommodations minus the difference between the hospital's customary charge for semiprivate accommodations and its customary charge for ward accommodations. In either case, the customary ward charge should be shown in the "Rate" column on the billing form.

D and E. Intensive care and self-care. Show the number of days the patient was in an intensive and/or self-care unit, applicable rate, and total charges.

Sometimes the patient will only be present in the intensive care unit for a few hours. In this case, the additional charge, without accommodation days, may be shown on Line D, and the usual accommodation days shown on Line A, B, or C. Also, the hospital may follow the practice of billing the accommodation charge to the semiprivate accommodation, and billing the additional intensive care charge, without an accommodation charge, to Line D. This is an acceptable method provided the intensive care charge excludes any charge for accommodation, and no days are shown in the intensive care days column.

F. Whole Blood. (See § 222 for an explanation of the deductible.)

Pints Furnished.—Enter the total number of pints of whole blood furnished whether or not replaced. This entry serves as a basis for counting pints toward the blood deductible and must therefore include both replaced and unreplaced blood.

Not Replaced.—Enter the total number of pints furnished less any pints which were donated on the patient's behalf. Where 1 pint is donated, 1 pint will be considered replaced.

Any blood which is furnished by a blood bank on behalf of the patient at no charge to the hospital is considered as replaced blood.

Charge Per Pint.—Where the patient does not replace all of the blood furnished, pint-for-pint, the hospital will show its usual charge per pint for unreplaced blood in the charge item.

Where a blood bank makes a "service" charge, and this charge applies equally to replaced and unreplaced blood, this charge will be considered a processing cost and will be charged to the program (in Line N) and not to the patient.

Example 1: The patient is furnished 4 pints of blood by a blood bank which donates the blood and makes a service charge of \$3 for each pint of blood whether replaced or not. This \$3 charge per pint is a

processing cost and no charge may be made to the patient. The entries for this situation would be as follows: Pints Furnished—4; Not Replaced—0. No entry is made in the Charge-Per-Pint block or the Total Charges column of Line F. In Line N “\$12” (3×4 pints) is shown in the Total Charges column.

Where a blood bank makes a “service” charge only for unreplaced blood, this charge will not be considered a processing charge, but a charge for whole blood. Therefore, the service charge for any of the first three pints of unreplaced blood subject to the blood deductible may be charged to the patient.

Example 2: The patient, who had 2 pints of the deductible remaining at the time of the present hospitalization, is furnished 4 pints of blood by a blood bank which donates the blood and makes only a service charge of \$3 for each pint of blood which is not replaced. This \$3 a pint charge for unreplaced blood is not a processing cost but is considered the cost of blood to the hospital. If the patient replaces only 1 pint of blood, the entries would be as follows: Pints Furnished—4; Not Replaced—3; Charge-Per-Pint—\$3; Total Charges—\$9. Unless the hospital charges its own administrative or processing charges, no entry would be made in Line N. In Line Q, one pint at \$3 a pint will be shown as the patient’s deductible liability.

Total Charge.—This should reflect the charge for unreplaced blood plus any additional charge which the hospital paid to an outside blood bank for blood that was not fully replaced under the blood bank’s blood replacement requirement.

A hospital which operates its own blood bank may not enter extra charges where it usually requires more than 1 pint of blood in replacement for each pint furnished.

Example 1: A hospital operated its own blood bank. It furnishes 3 pints of blood and the patient replaces 3. The hospital may not charge the patient for any of the 3 pints furnished and shows no charge in “Total Charges” for any replaced blood.

Where the hospital obtains blood from a **blood bank**, charges for blood furnished by the hospital to the program and to the patient for the blood deductible depend on the blood bank’s bill to the hospital.

Where **all** of the blood has been replaced according to the blood bank’s replacement requirements, no charge is made to either the program or patient for blood. Any service charge should be shown on Line N as a blood processing charge.

Where **not all** of the blood has been replaced according to the blood bank’s replacement requirements,

no charge is made to the patient if he replaces enough pints on a pint-for-pint basis to meet the blood deductible. If this requirement is not met, he may be charged for pints which are not replaced at the same charge per pint to the hospital as the pints furnished to him.

The amount to be entered in Total Charges on Line F is usually the total charge made by the blood bank after the patient’s replacement has been taken into account. However, this amount is subject to a maximum, which is determined as follows:

(1) Multiply the charge per pint by the number of pints furnished but not replaced.

(2) Multiply the charge per pint by the number of pints furnished but replaced. Take two-thirds of this figure and add it to the amount in (1).

Example 2: The patient is furnished 9 pints and replaces 2. The charge per pint furnished was \$30. The blood bank credits the hospital with \$30 for the 2 pints which were replaced. The blood bank bills the hospital \$240 for blood.

The hospital computes the maximum total charges for blood to be entered on Line F ($7 \times \$30$ plus $2 \times \$30 \times \frac{2}{3}$). The maximum is \$250; therefore \$240 is less than the maximum and is entered on Line F. The hospital charges the patient for 1 pint at \$30 and this amount is entered on Line Q.

Example 3: The patient is furnished 6 pints and replaces 3. The charge per pint furnished is \$20. The blood bank credits the hospital with \$15 for the 3 pints which were replaced. The blood bank bills the hospital for \$105.

The hospital computes the maximum total charges for blood to be entered on Line F ($3 \times \$20$ plus $3 \times \$20 \times \frac{2}{3}$). The maximum is \$100. The charge by the blood bank exceeds the maximum and \$100 is entered on Line F. No entry is made on Line Q since the patient has met the blood deductible by replacement.

In completing Line F, the Noncovered Charges column is used only where some blood charges are not covered or cannot be applied toward the deductible because, for example, they were incurred after exhaustion of benefits.

No charge may be made to the patient for any costs of processing, administration, or packaging. Blood processing, administration, and packaging charges should be shown on Line 17 N.

G—O. General. Item G includes recovery room and Item H includes intravenous solution.

Where items and services are furnished which are more expensive or in excess of the services covered by the program, the entries to be made in the Total

Charges and Noncovered Charges columns will be as follows:

1. If the patient **did not** request such excess or more expensive services, the patient may not be charged for the excess services, and only the services covered by the program should be shown in the Total Charges column. No entry is made in the Noncovered Charges column in this situation. (However, where all patients are routinely billed for such excess or more expensive items the Total Charge column may reflect the excess items or services as discussed in **Total and Noncovered Charges**, above.)

2. If the patient **did** request such excess or more expensive services, the patient may be charged for the excess services by the hospital. In this case, show the total charges (any customary charges covered by the program plus the excess charges), in the Total Charges column. In the Noncovered Charges column, show the excess charges which will be billed by the hospital to the patient.

3. In the same situation as cited in 2 above, except that the hospital will not bill the patient for the excess services, show only the customary charges for covered services in the Total Charges column and make no entry in the Noncovered Charges column.

P. Inpatient Deductible. The completion of this item depends on the remaining deductible that is shown on the report of eligibility received in reply to the Notice of Admission.

a. *Report of Eligibility Shows Remaining Inpatient Deductible as "None."*—No entry should be made in Line P in this situation.

b. *Report of Eligibility Shows \$40 as the Remaining Inpatient Deductible.*

(1) If Line O, Total Charges, shows an **amount equal to or greater than \$40**, show "\$40" in the Noncovered Charges column of Line P.

However, if the charge for physicians' services has been included in Total Charges (see discussion of the Total and Noncovered Charges columns, above), the physicians' services charge should be subtracted from Total Charges. If this results in covered charges of less than \$40, show the amount of the covered charges.

Example: The report of eligibility shows the remaining inpatient deductible as \$40. The Total Charges column of Line O is \$42 and the charge for physicians' services included in the \$42 is \$5. Therefore, the covered charges for deductible purposes would be \$37. Show this amount in Item P.

(2) If Line O, Total Charges, shows an **amount less than \$40**, enter the amount shown in Line O, Total Charges, in the Noncovered Charges column of Line P. If, as in (1) above, the Total Charges column includes charges for physicians' services, the difference between Total Charges and the physicians' services charges is the amount to be entered in Line P.

Where the Total Charges in Line O (or the difference between Line O and physicians' services charges) are actual charges which are less than customary charges, the proper entry in Line P would be the customary charges. (See § 220.)

c. *Report of Eligibility Shows Part of the Inpatient Deductible Remaining To Be Met.*—Follow the rules in b above, but use the amount of the remaining deductible as shown on the report of eligibility, rather than \$40.

Q. Blood Deductible. The dollar value of the whole blood for which the patient is responsible for paying is shown in Q. The patient is responsible for paying for whatever is not replaced of the first 3 pints furnished during a spell of illness. If the blood replaced equals the blood deductible shown on the intermediary's reply to the Notice of Admission, no entry is made in Line Q. However, if less blood is replaced than the remaining pints shown on the reply, the dollar charge for the unreplaced blood which went toward the deductible must be shown so that the appropriate deduction can be made in the reimbursement to the hospital.

R. Coinsurance. The coinsurance days are the 61st day through the 90th day. Show the number of coinsurance days, the coinsurance daily rate and the total deduction for coinsurance. The rate is \$10 or the daily charge, whichever is less.

S. Total Deductions. This is the total of Lines P, Q, and R. It does not include noncovered charges from Line O.

Item 18. Statement Covers Period. Enter the inclusive days being reported on the bill, whether or not these days are covered. Do not include days before the patient's entitlement to hospital insurance. Where the patient has not yet been discharged, enter the date of admission in the "From" item and the last day being billed in the "To" item. On the next bill, the "From" item contains the next day after the last day billed on the previous billing form. On the last bill submitted, the date of discharge should be shown in the "To" item.

Example: A hospital follows the practice of billing the intermediary on the 15th and last day of each month. The patient is admitted on July 5, 1967, and discharged

on August 14, 1967. On the bills submitted the Statement Covers Period would show:

	From	To
First bill.....	July 5, 1967	July 15, 1967
Second bill.....	July 16, 1967	July 31, 1967
Third bill.....	Aug. 1, 1967	Aug. 14, 1967

The item would be completed in this way whether or not all days are covered, e.g., benefits are exhausted or the patient was on leave for some days.

Item 19. Total Days. This is total **covered** days. Total days should not include—

- days for which no payment can be made because benefits are exhausted, unless the guarantee of payment applies;
- days for which no payment can be made because a workmen's compensation payment is being made or can be expected to be made;
- days for which no payment can be made because payment will be made under a National Institutes of Health grant;
- days for which services are not covered.

This includes, for example:

- emergency services after the emergency has ended;
- days for which inpatient care is not medically necessary or was for cosmetic surgery;
- days for which no payment can be made because the patient was on a leave of absence or is away from the hospital because of repeated admissions and discharges;
- day of discharge or death.

Except for a and f, the hospital should include a brief explanation of the reason why days are excluded in the Computation of Interim Payment block (Item 24), e.g., "Workmen's Compensation," "Noncovered Services," etc., and should give the precise dates for which no payment is being claimed in an attachment to the bill. (See § 450 for procedure for submitting billing in no-payment situations.)

Where a patient is admitted as an inpatient with the expectation that he will stay overnight but he is **discharged** before midnight, "1" will be entered in Total Days. Where a patient is **transferred** to another hospital before midnight (after admission with the expectation that he would remain overnight), 0 will be entered in this item. An accommodation charge may be made in this case even though Total Days will be entered as "0."

Where a patient is discharged on the first day of his entitlement, "0" will be shown in this item and no accommodation charge may be made.

Item 20. Date Guarantee of Payment or UR Notice Received. This item is not completed except where the guarantee of payment provision applies or where a notice is received from the utilization committee that further hospital services are not necessary. It should not be used routinely to enter the date the intermediary's reply to the Notice of Admission is received.

Enter in the item:

A. The date that the hospital received the report of eligibility (see § 286.2) showing that the number of inpatient days remaining was less than the number of inpatient days already provided in the current hospitalization.

B. The date of receipt by the hospital of the finding by the physician members of the Utilization Review Committee (or the group responsible for review of utilization) that a further hospital stay was not medically necessary (see § 290.2).

Cross out the item which does not apply.

The guarantee of payment provision does not apply unless the hospital establishes that it acted in good faith in assuming the individual was entitled to have payment made for hospital services, and acted reasonably in assuming that the patient's inpatient days had not been or were not about to be exhausted. See § 286. Where the guarantee of payment applies the hospital should attach a statement explaining the circumstances and itemize any payments received, or refunds made toward the bill.

Item 21. Date Benefits Exhausted. If the patient is still hospitalized and no further days are available, show the last day for which the benefits were payable. No entry should be made in this space when the reply to the Notice of Admission showed that no days are available. This item should not be completed unless benefits are exhausted before date of discharge or death, and during the period described in Item 18. A projected date should not be used.

Items 22 and 23. Discharge Information. If the patient is still hospitalized when the billing is submitted, check "Still Patient." Otherwise check "Discharged" or "Died" in Item 22. Show the date of discharge or death in Item 23.

Where a patient on leave of absence who was shown as "Still Patient" has not returned within 60 days, including the day the leave began, a corrected bill should be submitted per § 450 showing the day the patient left the hospital as the day of discharge. This will close the "open item" on the patient's utilization record. A notice of admission will be necessary if the patient returns after a 60-day absence.

INPATIENT PSYCHIATRIC OR TUBERCULOSIS HOSPITAL ADMISSION AND BILLING
HOSPITAL INSURANCE BENEFITS - SOCIAL SECURITY ACTForm Approved.
Budget Bureau
No. 72-R732

1. PATIENT'S LAST NAME			FIRST NAME		MI	2. HEALTH INSURANCE CLAIM NUMBER			
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)						4. DATE OF BIRTH		5. SEX <input type="checkbox"/> M <input type="checkbox"/> F	
6. HOSPITAL NAME AND ADDRESS				7. PROVIDER NO.		9. NAME AND ADDRESS OF ATTENDING PHYSICIAN			
				8. MEDICAL RECORD NO.					
10. ADMITTED TO ACTIVE CARE			11. NAME AND ADDRESS OF ANY INSTITUTION (including this institution) IN WHICH PATIENT RECEIVED INPATIENT CARE DURING LAST 60 DAYS (If this hospital, give dates of stay)						
12. NAME AND ADDRESS OF ANY PSYCHIATRIC OR TUBERCULOSIS INSTITUTION WHICH FURNISHED INPATIENT SERVICES AT ANY TIME DURING 90 DAY PERIOD PRECEDING EFFECTIVE DATE FOR HOSPITAL INSURANCE (If this hospital, give dates of stay)									
13. PAYMENT SOURCE FOR CHARGES TO PATIENT									
<input type="checkbox"/> SELF OR FAMILY <input type="checkbox"/> BLUE CROSS BLUE SHIELD <input type="checkbox"/> PUBLIC AGENCY (Give name) <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> EMPLOYER OR UNION <input type="checkbox"/> OTHER (Explain)									
14. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.									
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)								DATE	
15. ADMITTING OR CURRENT DIAGNOSIS EMPLOYMENT RELATED <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, give name and address of employer.)									
16. DISCHARGE DIAGNOSES OR CURRENT DIAGNOSES (Primary illness and secondary or complicating illnesses)								Do Not Use This Space	
17. SURGICAL PROCEDURES (Related to primary illness and other—Show date of each)									
STATEMENT OF SERVICES RENDERED				TOTAL CHARGES		NON-COVERED CHARGES		19. STATEMENT COVERS PERIOD FROM TO	20. TOTAL DAYS
ACCOMMODATION				DAYS		RATE			
A. 1-Bed									
B. 2-3-4 Bed									
C. 5 or more Beds									
D. Intensive Care									
E. Self Care									
F. WHOLE BLOOD				PINTS FURNISHED	NOT REPLACED	CHARGE PER PINT			
G. Operating Room									
H. Pharmacy									
I. Laboratory									
J. Radiology									
K. Medical, Surgical and Central Supplies									
L. Anesthesia									
M. Inhalation Therapy									
N. Other (Describe)									
O. TOTALS									
P. Inpatient Deductible									
Q. Blood Deductible				Pts. @					
R. Coinsurance									
S. TOTAL DEDUCTIONS									
I certify that the required physician's certification and recertifications are on file.									
28. SIGNATURE OF HOSPITAL REPRESENTATIVE					DATE FORWARDED		29. APPROVED BY		DATE

Item 24. Computation of Interim Payment. Payments to the hospital under the hospital insurance plan are based on the reasonable cost of services provided.

The precise reasonable cost of services cannot be determined until the end of the year when final cost figures are known. An interim settlement is made on the basis of each bill however. This interim settlement method will be established by the intermediary on the basis of the hospital's previous cost experience.

The hospital may wish to make a computation on its own copy of the form. If the hospital wishes to make a computation for its own records it can estimate the cost of covered services by the approved method and subtract the applicable deductible and coinsurance to arrive at the reimbursement amount.

Enter in this item an explanation for any noncovered days shown on the bill. (See Item 19 above and § 450.)

Item 25. Verified Prior-Stay Dates and Provider Number. DO NOT USE.

Item 26. Hospital Certification and Signature Line. A hospital representative should make sure that the required physician's certification and recertifications are in the hospital records. The representative should then sign and date the form before it is submitted to the intermediary. A stamped signature is acceptable. The date forwarded should be the date the bill is actually forwarded to the intermediary. The date used should not be before the "To" date in the "Statement Covers Period" item.

402.2 All-Inclusive Rate Hospitals.—For hospitals using all-inclusive rates, the line for the accommodation actually furnished is to be completed. The number of days, all-inclusive rate, total charges, and noncovered charges must be entered on the bill.

If the patient was furnished more than one type of accommodation, the lines for each type of accommodation are to be completed. This is necessary whether or not the hospital charges an all-inclusive rate according to accommodations.

In hospitals where the all-inclusive rate varies with the type of accommodation, an SSA-1484, Explanation of Accommodation Furnished, should be completed for a medically necessary private accommodation or for five or more bed accommodation. The semiprivate all-inclusive rate should be shown on the SSA-1484.

Item F. Whole Blood. Whenever whole blood is furnished in hospitals using all-inclusive rates, Line F must be completed. If the all-inclusive rate does not include the charge for whole blood, Line F should be completed in the same way a hospital not using all-

inclusive rates would complete this item. Pints furnished, pints not replaced, and charge per pint for the whole blood itself should be shown.

If the all-inclusive rate covers the cost of providing blood whenever a patient needs it, the number of pints furnished, not replaced, and the estimated cost per pint should be entered on Line F. It is not necessary to show any amount in the Total Charges column. The cost of any of the first 3 pints which are not replaced should be shown on Line Q. It is not necessary to show the cost for any replaced blood in Item 17.

Item P. Inpatient Deductible. As with hospitals having a schedule of charges for individual services, the amount of any **physician's component** included in the all-inclusive charge should be considered where the exclusion of the physician component would bring the charges below the remaining deductible to be met.

All-Inclusive Charges According to Disease, Injury, or Type of Treatment.—Those hospitals that have a charge system based on the patient's illness or injury or type of treatment should also complete the line(s) for type of accommodation showing number of days, rate, and total charges. The accommodation totals and the total amount (Line O) should be the same. Blood entries will be made in the manner indicated above.

402.3 Disposition of Copies of Completed Forms SSA-1453.—Retain the copy designated "Hospital Copy" and submit the remaining copies to your intermediary (or SSA in direct dealing situations). The remaining copies to be submitted to the intermediary or SSA constitute the following:

- a. The original copy which is maintained in the intermediary's (or SSA's) files.
- b. One copy designated "Social Security Administration Copy."
- c. The copy designated "Carrier Copy." The intermediary will send this copy to the intermediary processing physicians' bills.

410. INPATIENT PSYCHIATRIC OR TUBERCULOSIS ADMISSION AND BILLING (FORM SSA-1485)

The procedures for reporting admissions are described in Chapter III. The hospital fills out Items 1 through 15 of all copies of the form, detaches the bottom two copies, and notifies the intermediary in accordance with its usual procedures. The instructions for using the report of eligibility to determine the number of days for which payment may be made, and any deductibles for which the patient is responsible are contained in § 315.

Items 15 through 26 of the billing form should be completed at the time the bill is rendered. The bill may be rendered at the time the patient is discharged or after his benefits are exhausted. It also may be submitted on an interim basis in long-stay cases.

A billing form should also be submitted even though no program payment can be made—

- a. for periods after benefits are exhausted;
- b. when services are not covered;
- c. for the period after a utilization review finding that services are not medically necessary;
- d. when services are paid for, or can be expected to be paid for, by workmen's compensation;
- e. when services are paid for or will be paid for by a National Institutes of Health grant;
- f. when the patient or his representative refuses to request that payment be made on his behalf;
- g. when the physician refuses to certify for a reason other than lack of medical necessity.

Such bills enable the Social Security Administration and the intermediary to maintain correct current records of deductibles and days available. It is not necessary to complete all the items on a form when there are no covered days. See § 450 for the procedures for completing and submitting this kind of bill.

A hospital bill is also required when the deductible covers the entire amount of the hospital charges. A full bill is completed in these cases.

410.1 Completion of Billing Items on the Form SSA-1485.—

Item 16. Current or Discharge Diagnoses. Enter here all of the diagnoses shown on the face sheet or discharge sheet of the patient's hospital record which relate to the condition requiring the current hospitalization. The primary diagnosis should appear first. This is the diagnosis of the illness or condition which was the primary reason for the patient's hospitalization. Identify this primary diagnosis by writing the word "primary" in parentheses. Any remaining diagnoses should be listed in the same order in which they appear on the face sheet or discharge sheet. The diagnosis should be shown in accordance with recognized nomenclature, e.g., "Current Medical Terminology," or "Standard Nomenclature of Diseases and Operations."

Item 17. Surgical Procedures. Surgical procedures should be specified in detail using recognized nomenclature such as that used in "Current Medical Terminology," "Standard Nomenclature of Diseases

and Operations," etc. For the purposes of this form, surgery includes incision, excision, amputation, introduction, endoscopy, repair, destructions, suture, and manipulations.

Enter the name of the procedures, if any, shown on the face sheet or discharge sheet of the patient's hospital record which were performed during the period covered by the bill. Show the dates of each operation or endoscopic procedure listed. List first those procedures related to the primary diagnosis. List all other operation and endoscopic procedures in the same order as is shown on the face sheet or discharge sheet.

Item 18. Statement of Services. Show all charges for the period covered by the current billing for each of the departments. Where your hospital has more departments than shown on the form, combine the charges, where appropriate, for the purpose of completing the form. Where charges for a department not listed on the form are applied to one of the departments listed, all bills submitted should apply the same charges consistently to the same departments. For instance, if Recovery Room is applied to Line G—Operating Room, this should be done on a consistent basis, and should not be listed on Line N—Other—on any bills submitted.

Where there is insufficient space to describe all the services performed in N, Other, it is permissible to combine all other charges. Continuation sheet attachments for charges are not to be used. However, if it is necessary to explain a particular item, this may be done on an attachment.

Machine-Produced Ledger Sheets. Where the hospital wishes to submit machine-produced ledger sheets in lieu of the detailed completion of the Statement of Services item, it may do so if it has been following this practice for other insurance plans. The bill submitted by the hospital should contain departmental totals or subtotals. Hotel-type billings which summarize by day but not by department are not acceptable. Where the days, rate, and type of accommodation are not clear from the machine bill attachment, the hospital will make the accommodation entries. Also, unless blood furnished, replaced, and charge per pint is shown on the attachment, the hospital should complete Line F, Whole Blood.

Charges for services which are not covered should be fully identified either on the ledger sheet attached or in the "Noncovered Charges" column, unless such charges are routinely billed to all patients per discussion on Total and Noncovered Charges, below.

Any attachments, whether a machine bill or an explanation, should show the patient's name and health

insurance claim number and the hospital's name and address.

Showing Discounted Charges. Credit or minus entries should not be shown on the billing form. Where the hospital gives a discount to some patients, it can show charges in one of two ways. The charges can be shown as the full, undiscounted charge if full undiscounted charge data is accumulated for all patients for the purposes of the final cost reimbursement. The charges for the individual departments on the billing form should be shown as the discounted charges if the hospital, for the purposes of the final cost reimbursement, accumulates charges for all patients at the discounted rate.

Total and Noncovered Charges. In the Total Charge column the total charge for all services, covered and noncovered, will generally be shown. However, see Item 18A for the entries to be made when a patient is furnished private accommodations neither for medical reasons nor at his request, and the excess over semi-private accommodations will not be charged to him; and see Item 18 G-O for the rules for entries when items or services are furnished which are more expensive or in excess of those covered by the program.

In the **Noncovered Charges column** enter the amount of any noncovered charge **except** where the noncovered charge is routinely billed to medicare and nonmedicare patients alike. For instance, if it is the hospital's practice to bill nonmedicare patients for laboratory services which include the pathologist services as an integral part of such laboratory charge, the hospital should show the total laboratory charge, including the pathologist's component, in the Total Charges column **without breaking out the physician's component in the Noncovered Charge column.** (This does not preclude, of course, Part B billing by the hospital on behalf of the pathologist or by the pathologist on his own behalf, for services to the patient.)

Of course, if the hospital bills its patients for laboratory services which do not include the physician's component, the physician's component would not be shown in Total Charges. The purpose of this method of reporting is to maintain the integrity of the ratio of costs to charges for the final cost reimbursement settlement, which requires a uniform accounting report for medicare and nonmedicare patients.

Note, however, that noncovered charges cannot be applied to the deductible. See the explanation for Line P, Inpatient Deductible.

Where a bill is submitted for a period including both covered and noncovered days (e.g., benefits exhausted

during billing period), the charges for noncovered days are listed under noncovered charges. Where a billing form covers only noncovered days, only Line O, Totals, need be completed. See § 450 on submitting bills for noncovered days.

Items A-E. Accommodation. See § 210.1 for an explanation of the rules governing when other than semi-private accommodations are furnished.

Accommodation days should always be in terms of whole rather than fractional days. The accommodation days should not include the day of discharge even where the discharge was late.

However, where the hospital normally makes an extra charge for a late discharge it should enter the extra charge in Total Charges, though the extra or fractional day which the charge represents should not be entered in the Days item. Where this charge was made because the patient remained in the hospital after checkout time for his own convenience, the charge may be made to the patient and should be entered in the Noncovered column as a noncovered charge. However, where a patient's stay beyond the checkout hour is occasioned by his medical condition, e.g., a bedridden patient awaiting transfer to his home or to an extended care facility, the services furnished by the hospital are covered charges.

Ancillary charges for day of discharge, death, or the day on which a leave of absence begins, should be shown in the proper department.

Where the patient is discharged on his first day of entitlement, it is permissible to submit a billing form with no accommodation charge, but with ancillary charges shown in Lines F through N.

Where some of the days cannot be paid for because benefits were exhausted before discharge or death, show the charges for days after benefits were exhausted under noncovered charges.

Where more than one rate has been used for a given type of accommodation, one of the unused accommodation lines may be relettered and used to show the entry.

Example: Patient spends 10 days in a two-bed room at \$25 per day and is then moved to a four-bed room at \$22 per day. Line C, which was not used, may be relettered B and used to show the second accommodation.

A. One-bed. Where a patient needed a private room for medical reasons, complete and attach one copy of form SSA-1484 to explain the medical necessity. Enter the customary charge for a one-bed accommodation in the "Rate" column and complete the "Total Charges" column.

If the patient was in a one-bed accommodation for other than medical reasons, payment cannot be made

for more than the cost of semiprivate accommodations. (The completion of Form SSA-1484, Explanation of Accommodation Furnished, is not necessary in this case.)

1. If the patient requested a private room, the patient may be charged the difference between the private room charges and the most prevalent semiprivate room charges at the time of admission. If the hospital will charge him the difference, complete Item 18A showing the days, rate, and Total Charges for the private room accommodations.

In the Noncovered Charges column, show the difference between the private room charges and the most prevalent semiprivate room charges at the time of admission. (If the hospital does not charge the patient, complete Item 18B as in 2 below.)

2. If the patient did not request a private room, no charge may be made to him. In such a case, enter the most prevalent semiprivate rate, and the charges in the Total Charges column of Item 18B. No entry should be made in the Noncovered Charges column.

(See § 412.2, Item 6, for the method of figuring the most prevalent semiprivate rate. When the hospital is one which has only private accommodations, the most prevalent semiprivate accommodation rate is not applicable. In such a case, the hospital will use the equivalent semiprivate rate established by the intermediary in place of the most prevalent semiprivate rate. (See § 210.1B.))

B. *Two-, three-, or four-bed.* If the patient occupies semiprivate accommodations (two-, three-, or four-bed room) show the number of days and the actual daily rate for the accommodations.

C. *Five or more beds.* Under the hospital insurance program, payment is ordinarily made for semiprivate accommodations (two-, three-, or four-bed room). If the patient is assigned to a room with five or more beds, the hospital should complete Form SSA-1484, Explanation of Accommodation Furnished, explaining the reasons for this accommodation. Two copies of the form should be prepared and attached to the billing form where the patient did not request the accommodation. Where the patient requested the accommodation, only one copy of the SSA-1484 is required for attachment to the billing form. (See § 412 for instructions on use of form SSA-1484 and completion of items.)

Where the patient requested a five or more bed assignment, or the reason for assignment is one that the intermediary can approve, the reimbursement will be made for the reasonable cost of the actual accommoda-

tion furnished. However, where the ward accommodation was provided **not** at the patient's request, nor for a reason which the intermediary can approve, payment will be made, at the end of the year settlement, on the basis of the reasonable cost of semiprivate accommodations minus the difference between the hospital's customary charge for semiprivate accommodations and its customary charge for ward accommodation. In either case, the customary ward charge should be shown in the "Rate" column on the billing form.

D. and E. *Intensive Care and Self-Care.* Show the number of days the patient was in an intensive and/or self-care unit, applicable rate, and total charges.

Sometimes the patient will only be present in the intensive care unit for a few hours. In this case, the additional charge, without accommodation days, may be shown on Line D, and the usual accommodation days shown on Line A, B, or C. Also, the hospital may follow the practice of billing the accommodation charge to the semiprivate accommodation, and billing the additional intensive care charge, without an accommodation charge, to Line D. This is an acceptable method provided the intensive care charge excludes any charge for accommodation, and no days are shown in the intensive care days column.

F. *Whole Blood.* (See § 222 for an explanation of the deductible.)

Pints Furnished.—Enter the total number of pints of whole blood furnished whether or not replaced. This entry serves as a basis for counting pints toward the blood deductible and must therefore include both replaced and unreplaced blood.

Not Replaced.—Enter the total number of pints furnished less any pints which were donated on the patient's behalf. Where 1 pint is donated, 1 pint will be considered replaced.

Any blood which is furnished by a blood bank on behalf of the patient at no charge to the hospital is considered as replaced blood.

Charge Per Pint.—Where the patient does not replace all of the blood furnished, pint for pint, the hospital will show its usual charge per pint for unreplaced blood in the charge item.

Where a blood bank makes a "service" charge, and this charge applies equally to replaced and unreplaced blood, this charge will be considered a processing cost and will be charged to the program (in Line N) and not to the patient.

Example 1: The patient is furnished 4 pints of blood by a blood bank which donates the blood and makes a service charge of \$3 for each pint of blood

whether replaced or not. This \$3 charge per pint is a processing cost and no charge may be made to the patient. The entries for this situation would be as follows: Pints Furnished—4; Not Replaced—0. No entry is made in the Charge Per Pint block or the Total Charges column of Line F. In Line N “\$12” ($\3×4 pints) is shown in the Total Charges column.

Where a blood bank makes a “service” charge only for unreplaced blood, this charge will not be considered a processing charge, but a charge for whole blood. Therefore, the service charge for any of the first 3 pints of unreplaced blood subject to the blood deductible may be charged to the patient.

Example 2: The patient, who had 2 pints of the deductible remaining at the time of the present hospitalization, is furnished 4 pints of blood by a blood bank which donates the blood and makes only a service charge of \$3 for each pint of blood which is not replaced. This \$3 a pint charge for unreplaced blood is not a processing cost but is considered the cost of blood to the hospital. If the patient replaced only one pint of blood, the entries would be as follows: Pints Furnished—4; Not Replaced—3; Charge Per Pint—\$3; Total Charges—\$9. Unless the hospital charges its own administrative or processing charges, no entry would be made in Line N. In Line Q, 1 pint at \$3 a pint will be shown as the patient’s deductible liability.

Total Charge.—This should reflect the charge for unreplaced blood plus any additional charge which the hospital paid to an outside blood bank for blood that was not fully replaced under the blood bank’s blood replacement requirement.

A hospital which operates its own blood bank may not enter extra charges where it usually requires more than 1 pint of blood in replacement for each pint furnished.

Example 1: A hospital operates its own blood bank. It furnishes 3 pints of blood and the patient replaces 3. The hospital may not charge the patient for any of the 3 pints furnished and shows no charge in “Total Charges” for any replaced blood.

Where the hospital obtains blood from a **blood bank**, charges for blood furnished by the hospital to the program and to the patient for the blood deductible depend on the blood bank’s bill to the hospital.

Where **all** of the blood has been replaced according to the blood bank’s replacement requirements, no charge is made to either the program or patient for blood. Any service charge should be shown on Line N as a blood processing charge.

Where **not all** of the blood has been replaced according to the blood bank’s replacement requirements, no charge is made to the patient if he replaces enough pints on a pint for pint basis to meet the blood deductible. If this requirement is not met, he may be charged for pints which are not replaced at the same charge per pint to the hospital as the pints furnished to him.

The amount to be entered in Total Charges on Line F is usually the total charge made by the blood bank after the patient’s replacement has been taken into account. However, this amount is subject to a maximum, which is determined as follows:

(1) Multiply the charge per pint by the number of pints furnished but not replaced.

(2) Multiply the charge per pint by the number of pints furnished but replaced. Take two-thirds of this figure and add it to the amount in (1).

Example 2: The patient is furnished 9 pints and replaces 2. The charge per pint furnished was \$30. The blood bank credits the hospital with \$30 for the 2 pints which were replaced. The blood bank bills the hospital \$240 for blood.

The hospital computes the maximum total charges for blood to be entered on Line F ($7 \times \$30$ plus $2 \times \$30 \times \frac{2}{3}$). The maximum is \$250; therefore \$240 is less than the maximum and is entered on Line F. The hospital charges the patient for 1 pint at \$30 and this amount is entered on Line Q.

Example 3: The patient is furnished 6 pints and replaces 3. The charge per pint furnished is \$20. The blood bank credits the hospital with \$15 for the 3 pints which were replaced. The blood bank bills the hospital for \$105.

The hospital computes the maximum total charges for blood to be entered on Line F ($3 \times \$20$ plus $3 \times \$20 \times \frac{2}{3}$). The maximum is \$100. The charge by the blood bank exceeds the maximum and \$100 is entered on Line F. No entry is made on Line Q since the patient has met the blood deductible by replacement.

In completing Line F, the Noncovered Charges column is used only where some blood charges are not covered or cannot be applied toward the deductible because, for example, they were incurred after exhaustion of benefits.

No charge may be made to the patient for any costs of processing, administration, or packaging. Blood processing, administration, and packaging charges should be shown on Line N.

G—O. *General.* Item G includes recovery room and Item H includes intravenous solution.

Where items and services are furnished which are more expensive or in excess of the services covered by the program, the entries to be made in the Total Charges and Noncovered Charges columns will be as follows:

1. If the patient **did not** request such excess or more expensive services, the patient may not be charged for the excess services, and only the services covered by the program should be shown in the Total Charges column. No entry is made in the Noncovered Charges column in this situation. (However, where all patients are routinely billed for such excess or more expensive items the Total Charges column may reflect the excess items or services as discussed in **Total and Noncovered Charges**, above.)

2. If the patient **did** request such excess or more expensive services, the patient may be charged for the excess services by the hospital. In this case, show the total charges (any customary charges covered by the program plus the excess charges), in the Total Charges column. In the Noncovered Charges column, show the excess charges which will be billed by the hospital to the patient.

3. In the same situation as cited in 2 above, except that the hospital will not bill the patient for the excess services, show only the customary charges for covered services in the Total Charges column and make no entry in the Noncovered Charges column.

P. Inpatient Deductible. The completion of this item depends on the remaining deductible that is shown on the Report of Eligibility received in reply to the Notice of Admission, and the rules for applying the greater of either the customary or actual charges to the deductible as discussed in § 220.

a. *Report of Eligibility Shows Remaining Inpatient Deductible as "None."*—No entry should be made in Line P in this situation.

b. *Report of Eligibility Shows \$40 as the Remaining Inpatient Deductible.*

(1) If Line O, Total Charges, shows an **amount equal to or greater than \$40**, show "\$40" in the Noncovered Charges column of Line P.

However, if the charge for physicians' services has been included in Total Charges (see discussion of the Total and Noncovered Charges columns, above), the physicians' services charged should be subtracted from Total Charges. If this results in covered charges of less than \$40, show the amount of the covered charges.

Example: The report of eligibility shows the remaining inpatient deductible as \$40. The Total

Charges column of Line O is \$42 and the charge for physicians' services included in the \$42 is \$5. Therefore, the covered charges for deductible purposes would be \$37. Show this amount in Item P.

(2) If Line O, Total Charges, shows an **amount less than \$40**, enter the amount shown in Line O, Total Charges, in the Noncovered Charges column of Line P. If, as in (1) above, the Total Charges column includes charges for physicians' services, the difference between Total Charges and the physicians' services charges is the amount to be entered in Line P.

Where the Total Charges in Line O (or the difference between Line O and physicians' services charges) are actual charges which are less than customary charges, the proper entry in Line P would be the customary charges. (See § 220.)

c. *Report of Eligibility Shows Part of the Inpatient Deductible Remaining To Be Met.*—Follow the rules in b above, but use the amount of the remaining deductible as shown on the Report of Eligibility, rather than \$40.

Q. Blood deductible. The dollar value of the whole blood for which the patient is responsible for paying is shown in Q. The patient is responsible for paying for whatever is not replaced of the first 3 pints furnished during a spell of illness. If the blood replaced equals the blood deductible shown on the reply to the Notice of Admission, then no entry is made in Line Q. However, if less blood is replaced than the remaining pints shown on the reply, the dollar charge for the unreplaced blood which went toward the deductible must be shown so that the appropriate deduction can be made in the reimbursement to the hospital.

R. Coinsurance. The coinsurance days are the 61st day through the 90th day. Show the number of coinsurance days, the coinsurance daily rate and the total deduction for coinsurance. The rate is \$10 or the daily charge, whichever is less.

If a patient was receiving care in a qualified psychiatric or tuberculosis hospital, or distinct part of a psychiatric or tuberculosis hospital, in the 90 days before his entitlement to hospital insurance, these days may count against the 90 days available in his first spell of illness. However, they do not count toward the 190-day limit on inpatient psychiatric hospital services. Also, for the purpose of figuring when coinsurance first applies, **the inpatient psychiatric or tuberculosis hospital** days before entitlement are not counted. (See § 225 for a discussion and example of this provision.)

S. Total deductions. This is the total of Lines P, Q, and R. It does not include noncovered charges from Line O.

Item 19. Statement Covers Period. Enter the inclusive days being reported on the bill, whether or not these days are covered. Do not include days before the patient's entitlement to hospital insurance. Where the patient has not yet been discharged, enter the date of admission in the "From" item and the last day being billed in the "To" item. On the next bill, the "From" item contains the next day after the last day billed on the previous billing form. On the last bill submitted, the date of discharge should be shown in the "To" item.

Example: A hospital follows the practice of billing the intermediary on the 15th and last day of each month. The patient is admitted on July 5, 1967, and discharged on August 14, 1967. On the bills submitted the Statement Covers Period would show:

	From	To
First bill.....	July 5, 1967	July 15, 1967
Second bill.....	July 16, 1967	July 31, 1967
Third bill.....	Aug. 1, 1967	Aug. 14, 1967

The item would be completed in this way whether or not all days are covered, e.g., benefits are exhausted or the patient was on leave for some days.

Item 20. Total Days. This is total covered days. Total days should not include—

a. days for which no payment can be made because benefits are exhausted, unless the guarantee of payment applies;

b. days for which no payment can be made because a workmen's compensation payment is being made or can be expected to be made;

c. days for which no payment can be made because payment will be made under a National Institutes of Health grant;

d. days for which services are not covered. This includes, for example:

1. emergency services after the emergency has ended;

2. days for which inpatient care is not medically necessary or was for cosmetic surgery;

e. days for which no payment can be made because the patient was on a leave of absence or is away from the hospital because of repeated admissions and discharges;

f. day of discharge or death or the day on which active treatment ended.

Except for a and f, the hospital should include a brief explanation of the reason why days are excluded in the Computation of Interim Payment block (Item 26), e.g.,

"Workmen's Compensation," "Noncovered Services," etc., and should give the precise dates for which no payment is being claimed in an attachment to the bill. (See § 450 for procedure for submitting billing in no-payment situations.)

Where a patient is admitted as an inpatient with the expectation that he will stay overnight but he is **discharged** before midnight, "1" will be entered in Total Days. Where a patient is **transferred** to another hospital before midnight (after admission with the expectation that he would remain overnight), 0 will be entered in this item. An accommodation charge may be made in this case even though Total Days will be entered as "0."

Where a patient is discharged on the first day of his entitlement, "0" will be shown in this item and no accommodation charge may be made.

Item 21. Date Active Care Ended. Show the date on which active treatment ended. If this is an interim billing and the patient is still receiving active treatment, check "Continuing."

Item 22. Date Guarantee of Payment or UR Notice Received. This item is not completed except where the guarantee of payment provision applies or where a notice is received from the utilization committee that further hospital services are not necessary. It should not be used to routinely enter the date the reply to the Notice of Admission is received.

Enter in the item—

A. The date that the hospital received the Report of Eligibility (see § 286.2) showing that the number of inpatient days remaining was less than the number of inpatient days already provided in the current hospitalization.

B. The date of receipt by the hospital of the finding by the physician members of the Utilization Review Committee (or the group responsible for review of utilization) that a further hospital stay was not medically necessary (see § 290.2).

Cross out the item which does not apply.

The guarantee of payment provision does not apply unless the hospital establishes that it acted in good faith in assuming the individual was entitled to have payment made for hospital services, and acted reasonably in assuming that the patient's inpatient days had not been or were not about to be exhausted. See § 286. Where the guarantee of payment applies, the hospital should attach a statement explaining the circumstances and itemize any payments received, or refunds made toward the bill.

Item 23. Date Benefits Exhausted. If the patient

is still hospitalized and no further days are available, show the last day for which the benefits were payable. No entry should be made in this space when the reply to the Notice of Admission showed that no days are available. This item should not be completed unless benefits are exhausted before date of discharge or death, and during the period described in Item 19. A projected date should not be used.

Items 24 and 25. Discharge Information. If the patient is still hospitalized when the billing is submitted, check "Still Patient." Otherwise check "Discharged" or "Died" in Item 24. Show the date of discharge or death in Item 25.

Where a patient on leave of absence who was shown as "Still Patient" has not returned within 60 days, including the day the leave began, a corrected bill should be submitted per § 450 showing the day the patient left the hospital as the day of discharge. This will close the "open item" on the patient's utilization record. A notice of admission will be necessary if the patient returns after a 60-day absence.

Item 26. Computation of Interim Payment. Payments to the hospital under the hospital insurance plan are based on the reasonable cost of services provided.

The precise reasonable cost of services cannot be determined until the end of the year when final cost figures are known. An interim settlement is made on the basis of each bill, however. This interim settlement method will be established by the intermediary on the basis of the hospital's previous cost experience.

The hospital may wish to make a computation on its own copy of the form. If the hospital wishes to make a computation for its own records it can estimate the cost of covered services by the approved method and subtract the applicable deductible and coinsurance to arrive at the reimbursement amount.

Enter in this item an explanation for any noncovered days shown on the bill. (See Item 20 above and § 450.)

Item 27. Verified Prior Stay Dates and Provider Number. DO NOT USE.

Item 28. Hospital Certification and Signature Line. A hospital representative should make sure that the required physician's certification and recertifications are in the hospital records. The representative should then sign and date the form before it is submitted to the intermediary. A stamped signature is acceptable. The date forwarded should be the date actually forwarded to the intermediary. The date used should not be before the "To" date in the "Statement Covers Period" item.

410.2 All-Inclusive Rate Hospitals.—For hospitals using all-inclusive rates, the line for the accommodation actually furnished is to be completed. The number of days, all-inclusive rate, total charges, and uncovered charges must be entered on the bill.

If the patient was furnished more than one type of accommodation, the lines for each type of accommodation are to be completed. This is necessary whether or not the hospital charges an all-inclusive rate according to accommodations.

In hospitals where the all-inclusive rate varies with the type of accommodation, an SSA-1484, Explanation of Accommodation Furnished, should be completed for a medically necessary private accommodation or for five or more bed accommodation. The semi-private all-inclusive rate should be shown on the SSA-1484.

Item F. Whole Blood. Whenever whole blood is furnished in hospitals using all-inclusive rates, Line F must be completed. If the all-inclusive rate does not include the charge for whole blood, Line F should be completed in the same way a hospital not using all-inclusive rates would complete this item. Pints furnished, pints not replaced, and charge per pint for the whole blood itself should be shown.

If the all-inclusive rate covers the cost of providing blood whenever a patient needs it, the number of pints furnished, not replaced, and the estimated cost per pint should be entered on Line F. It is not necessary to show any amount in the Total Charges column. The cost of any of the first 3 pints which are not replaced should be shown on Line Q. It is not necessary to show the cost for any replaced blood in Item 18.

Item P. Inpatient Deductible. As with hospitals having a schedule of charges for individual services, the amount of any **physician's component** included in the all-inclusive charge should be considered where the exclusion of the physician component would bring the charges below the remaining deductible to be met.

All-Inclusive Charges According to Disease, Injury, or Type of Treatment. Those hospitals that have a charge system based on the patient's illness or injury or type of treatment should also complete the line(s) for type of accommodation showing number of days, rate, and total charges. The accommodation totals and the total amount (Line O) should be the same. Blood entries will be made in the manner indicated above.

410.3 Disposition of Copies of Completed Forms SSA-1485.—Retain the copy designated "Hospital Copy" and submit the remaining copies to

your intermediary (or SSA in direct dealing situations). The remaining copies to be submitted to the intermediary or SSA constitute the following:

- a. The original copy which is maintained in the intermediary's (or SSA's) files.
- b. One copy designated "Social Security Administration Copy."
- c. The copy designated "Carrier Copy." The intermediary will send this copy to the intermediary processing physicians' bills.

412. EXPLANATION OF ACCOMMODATION FURNISHED (FORM SSA-1484)

Form SSA-1484, Explanation of Accommodation Furnished, is used by the hospital to explain an accommodation other than a two-, three-, or four-bed room.

The cost of a one-bed accommodation is covered by hospital insurance if it is medically necessary. In this case, only one copy of the form is required. The medical necessity for a private accommodation should be described on the SSA-1484 from the physician's order and the reason as given by him in the hospital's medical record. It is not necessary to attach a special statement from the doctor for this purpose.

Where the patient was furnished a one-bed accommodation for reasons other than medical necessity, it is not necessary to complete a form SSA-1484.

Where the patient requested a five-bed accommodation, the hospital should complete a single copy of the SSA-1484 for attachment to the bill and have the patient sign the form in the Patient's Signature block under Item 7A.

Where the patient was assigned a five-bed accommodation not at his request, the hospital should complete the SSA-1484 in duplicate for attachment to the bill showing the reason for such assignment. Where such an assignment is made not at the patient's request and not for a reason the intermediary approves, i.e., a reason not consistent with the purposes of the program, the hospital may be subject to a special deduction in its cost settlement described in § 210.1C.

A hospital need not complete this form on individual claims where the intermediary had given its general approval for the omission of the form. This would usually only be given by the intermediary where the hospital has only five or more bed accommodations.

412.1 Completing Items on the Form SSA-1484.

Item 1. Patient Identification. This should be the same name shown on the inpatient billing form to which the SSA-1484 will be attached.

Item 2. Health Insurance Claim Number. This

should be the same number shown on the billing form.

Item 3. Hospital or Extended Care Facility Name and Address. The name and address of the hospital is shown here.

Item 4. Provider Number. This is the hospital's assigned health insurance provider number.

Item 5. Medical Record Number. This is the patient's medical record number, if one is assigned by the hospital.

Item 6. Type of Accommodation Furnished. This section calls for the period for which the accommodation was furnished and the applicable daily rate for the accommodation furnished. Item A, the most prevalent semiprivate rate, should be completed in all cases. This is the semiprivate rate most frequently used in the hospital. (A hospital with private rooms only will use the equivalent semiprivate rate determined by the intermediary.)

To determine the most prevalent charge for semiprivate accommodations:

- (1) Type of accommodation.
- (2) Total rooms of each type for each different room rate.
- (3) Total beds found in each type for each room rate.
- (4) Rate you charge daily for the type of room.
- (5) Your most prevalent charge for semiprivate accommodations is that single rate that you charge for the largest entry appearing under your "total beds" column.

Example:

(1) Type of accommodation	(2) Total rooms of this type	(3) Total beds col. (1) × col. (2)	(4) Rate per day
2 beds.....	10	20	\$30
2 beds.....	8	16	35
3 beds.....	2	6	20
4 beds.....	1	4	15

Note: \$30 is the most prevalent semiprivate charge.

Item 7. Reason for Assignment to Accommodation Mentioned.

A. Patient's Request. Where a five or more bed accommodation was furnished at a patient's request, the patient should be requested to sign the SSA-1484 in this item. Enter the date of signing.

B. Medical Necessity. Describe the reason for assignment to a one-bed room from the physician's order shown in the hospital's records.



EXPLANATION OF ACCOMMODATION FURNISHED

1. PATIENT'S LAST NAME	2. HEALTH INSURANCE CLAIM NUMBER
3. HOSPITAL OR EXTENDED CARE FACILITY NAME AND ADDRESS	4. PROVIDER NO.
	5. MEDICAL RECORD NO.

TYPE OF ACCOMMODATION FURNISHED

6A. MOST PREVALENT SEMI-PRIVATE RATE			\$		
B. 1-BED			C. 5-OR-MORE-BED		
FROM (Date)	TO (Date)	RATE	FROM (Date)	TO (Date)	RATE

REASON FOR ASSIGNMENT TO ACCOMMODATION MENTIONED

7A. PATIENT'S REQUEST - The 5-or-more-bed accommodation shown above was furnished because I requested it.

PATIENT'S SIGNATURE	DATE
---------------------	------

B. MEDICAL NECESSITY (Describe)

C. OTHER REASON (Specify)

D. SIGNATURE OF HOSPITAL REPRESENTATIVE	E. DATE
---	---------

FOR INTERMEDIARY USE

<p>9. Where intermediary determines that assignment to 5-or-more-bed room was not at patient's request, or was not consistent with the purposes of the Act, give difference between total of charges for accommodation at the most prevalent 2-3-4 bed room rate and charges for a 5-or-more-bed room for all covered days included on bill for services attached.</p>	\$
10. INTERMEDIARY APPROVAL	DATE

C. *Other Reasons.* Where the hospital believes that an assignment to a five or more bed accommodation is justifiable for some other reason, it should describe the reason in this block.

D. *Signature of Hospital Representative.* The responsible hospital representative should sign and date the form in this item. A stamped signature is acceptable.

Item 8. Date. Show the date the signature in 7D was affixed.

Items 9 and 10. DO NOT USE.

420. OUTPATIENT HOSPITAL BILLING (FORM SSA-1483)

This form should be used by the hospital to claim reimbursement for all outpatient services and for other services covered under medical insurance which will occasionally be billed as outpatient services. Outpatient hospital services covered by the hospital insurance plan are described in §§ 232 and 236, outpatient services covered under the medical insurance plan are described in §§ 234 and 240.2, and other services covered under medical insurance in §§ 240.1, 240.3, and 240.4.

A. *When to Submit This Form.* If the items or services are reimbursable only under the medical plan, send the completed form to the intermediary (or to SSA if you deal directly) as soon as possible.

The hospital should bill for a complete diagnostic study under the hospital plan, but not more than one diagnostic study on the same billing form. Any medical plan charges that can be billed at the same time as the diagnostic charges should be reported on the same billing form.

If there are charges only under the hospital plan, submit it after 20 days or when the diagnostic services are completed, whichever is earlier.

If services or items are reimbursable under both hospital and medical insurance, you may submit the bill showing both types of services as soon as possible or after 20 days, whichever you find most convenient and appropriate for the individual's course of tests or treatment.

Sometimes, after a hospital believed a study had ended, a patient may return for additional diagnostic tests after the bill has been submitted but within the 20-day period specified in § 236. If this should happen, only one \$20 deductible applies to all services within the 20-day period.

Occasionally, diagnostic services may last more than 20 days. Treat diagnostic services beginning with the 21st day as a new diagnostic study, and pre-

pare a new billing form for the next 20-day period, applying another \$20 deductible.

There are a number of situations where a **fully completed bill** should be submitted despite the fact that the hospital will not receive reimbursement. Such situations include:

1. The illness or injury is employment related and payment has been, or will be, made under workmen's compensation.

2. Covered services have been rendered but the deductible has not been satisfied.

3. Noncovered services have been rendered to an entitled beneficiary.

No billing form should be submitted if the patient has received services covered only under the medical plan, and he is not entitled to benefits under this plan.

B. *Determining How Much To Charge Outpatient Before Billing Is Submitted.* The deductibles and coinsurance payable under the hospital insurance plan for outpatient services are described in §§ 236.2 and 236.3. The deductibles and coinsurance for the medical insurance plan are described in §§ 246 and 247.

The \$20 deductible under the hospital plan for outpatient diagnostic services is an incurred expense under the medical insurance plan. (See § 248.)

The hospital may be able to determine from its records or from the patient that the medical plan deductible has already been met or the extent to which it has been met. (The patient is sent a notice which tells him the remaining deductible whenever a bill is submitted.)

When the intermediary receives an outpatient billing, it will check its records or query the Social Security Administration central record for the Part B deductible status information required for computing the payments.

1. *Patient Has Both Hospital and Medical Plan Entitlement.*—

(a) *Medical Plan Deductible Is Not Met Or Its Status Is Unknown.*—You may prefer to wait to bill the patient until the intermediary has verified the deductible status. If you do bill the patient, any overcollection of the deductible and coinsurance will be refunded directly to the patient by the intermediary.

The hospital can use these guidelines in billing:

(1) *Patient has diagnostic services only.* Charge up to \$20 plus 20 percent of any balance in excess of \$20.

(2) *Patient has medical plan services only.* Charge not more than the \$50 deductible and 20 percent of any balance.

OUTPATIENT HOSPITAL BILLING
HOSPITAL AND MEDICAL INSURANCE BENEFITS - SOCIAL SECURITY ACTForm Approved.
Budget Bureau No. 72-R738

1. PATIENT'S LAST NAME			FIRST NAME		MI	2. HEALTH INSURANCE CLAIM NUMBER			
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)						4. DATE OF BIRTH		5. SEX <input type="checkbox"/> M <input type="checkbox"/> F	
6. HOSPITAL NAME AND ADDRESS				7. PROVIDER NO.		9. NAME AND ADDRESS OF PHYSICIAN REQUESTING OUTPATIENT SERVICES			
				8. MEDICAL RECORD NO.					
10. PAYMENT SOURCE FOR CHARGES TO PATIENT <input type="checkbox"/> SELF OR FAMILY <input type="checkbox"/> BLUE CROSS BLUE SHIELD <input type="checkbox"/> PUBLIC AGENCY (Give name) <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> EMPLOYER OR UNION <input type="checkbox"/> OTHER (Explain)								11. DATE OF FIRST VISIT	
12. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf. SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)								DATE	
13. DIAGNOSES (Primary illness and secondary or complicating illnesses)						EMPLOYMENT RELATED <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, give name and address of employer.		Leave Blank	
14. DATE OF EACH SERVICE		FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN			TOTAL CHARGES	HOSPITAL PLAN CHARGES	MEDICAL PLAN CHARGES	NON-COVERED CHARGES	
15A. Total Occasions of Service		HOSPITAL PLAN	MEDICAL PLAN	15B. Total Charges	\$	\$	\$	\$	
16. Professional component included in 15B total charges								FOR INTERMEDIARY USE	
17. 15B total charges less professional component shown in 16								VERIFIED PATIENT LIABILITY	
18. PATIENT PAID		A. Deductible							
		B. Coinsurance							
FOR INTERMEDIARY USE								PAYMENT DISTRIBUTION	
19. PART A		A. REIMB. RATE	B. A TIMES 15	C. DEDUCTIBLE	D. B LESS C	E. 80% OF D	HOSPITAL	PATIENT	
20. PART B									
21. PART A DEDUCTIBLE AS PART B EXPENSE		A. DEDUCTIBLE AMOUNT	B. REMAINING PART B DEDUCTIBLE	C. A LESS B	D. 80% OF C				
						TOTALS	\$	\$	
I certify that the required physician's certification on file.									
22. SIGNATURE OF HOSPITAL REPRESENTATIVE					DATE FORWARDED		23. APPROVED BY		DATE

(3) *Patient has a mixture of diagnostic and therapeutic services.* For diagnostic services, charge up to \$20 plus 20 percent of any balance. For therapeutic services, charge the amount necessary to meet the \$50 medical plan deductible (after considering the amount of the diagnostic deductible charge as an incurred expense under the medical plan) and 20 percent of any balance.

(b) *Medical Plan Deductible Is Met.*—Charge 20 percent of the total, whether the services are diagnostic or therapeutic.

2. Patient Has Hospital Plan Entitlement Only.—Only diagnostic services are covered. Charge up to \$20 plus 20 percent of any remainder and the full amount of any charges for therapeutic services.

3. Patient Has Medical Plan Entitlement Only.—Both diagnostic and therapeutic services are covered under the medical plan.

Where the deductible is known to be met, charge 20 percent of the total.

Where the deductible is not met or its status is unknown, charge no more than \$50 and 20 percent of any balance. Here the hospital may prefer to wait to bill the patient until the intermediary has verified the deductible status.

C. Billing Examples.—

Example 1: Hospital knows patient has met Part B deductible. Outpatient hospital diagnostic services reasonable charge is \$40. The hospital bills the patient \$8 (20 percent of the total). The intermediary reimburses the hospital 80 percent of the \$20 Part A deductible (\$16), plus 80 percent of the estimated reasonable cost of the services above the \$20 Part A deductible.

Example 2: Patient has met Part B deductible, but hospital has not been able to ascertain that fact. Outpatient hospital diagnostic services reasonable charge is \$40. Hospital bills patient \$24 (the \$20 Part A deductible, plus 20 percent of the remainder).

Intermediary determines by querying SSA central records that Part B deductible had been met. The intermediary reimburses the hospital for 80 percent of the reasonable cost above the \$20 deductible and reimburses the patient \$16 (80 percent of the \$20 Part A deductible).

Example 3: It is uncertain whether the patient has met Part B deductible. Outpatient hospital diagnostic services reasonable charge is \$40. Hospital chooses not to bill the patient until the intermediary has verified the deductible.

The intermediary queries the SSA central record and determines that the patient had not met any part of the Part B deductible. It reimburses the hospital 80 percent of the estimated reasonable cost of the services above the \$20 Part A deductible, and informs the hospital it should bill the patient for \$24, i.e., the Part A deductible, plus \$4 coinsurance.

Example 4: Patient has \$80 in diagnostic services and \$40 in therapeutic services. The hospital believes the medical plan deductible is not met and decides to bill the patient at the same time the billing form is sent to the intermediary.

The hospital bills the patient:

\$20	for the diagnostic deductible;
12	hospital plan coinsurance;
30	medical plan deductible (considering \$20 diagnostic deductible as an incurred Part B expense);
2	coinsurance on the \$10 remaining medical plan charges.

\$64 Total

420.1 Completing Items on Form SSA-1483.—

Item 1. Patient Identification. Enter the patient's last name, first name, and middle initial from his health insurance card, or other notice.

Item 2. Health Insurance Claim Number. Enter the patient's claim number as shown on his health insurance card, certificate of award, utilization notice, temporary eligibility notice, or as reported by the social security district office.

Item 3. Patient's Address. Show the patient's mailing address from your records. Where the patient's authorized representative is signing the form on behalf of the patient, show the authorized representative's address.

Items 4 and 5. Date of Birth and Sex. Enter the patient's date of birth and sex. If the date of birth is unknown, the hospital should transmit the bill without the date of birth. If only the year of birth is known, but not the month or day, show the year. While the date of birth is useful as identification and should be shown when available, a billing can be processed without the date of birth.

Items 6, 7, and 8. Hospital Identification. Enter the name and address of the hospital and the hospital's assigned provider number. These items can be preprinted on all copies of this form, if desired. Enter the patient's medical record number only if one is assigned by the hospital for its own filing purposes.

Item 9. Name and Address of Physician Request-

ing Outpatient Services.—Show the name of the physician who requested outpatient services. Show his address only if your intermediary requires it.

Item 10. Payment Source. Check the appropriate box(es) to identify who will pay any charges that will not be paid for under the health insurance program. This item may be completed either at the time of admission or when billing. More than one source may be checked, if applicable. If the hospital will not bill anyone for expenses not reimbursable under the program, the item need not be completed.

When some or all of the charges are payable under a federally supported assistance program of the Social Security Act, the hospital should identify the public agency in addition to checking the box. Enter the agency's name and address, and the patient's case number, if available. The intermediary may find it necessary to forward a copy of the form to the public agency.

Item 11. Date of First Visit. This date should be the first date on which the patient was seen for the purpose of a 20-day diagnostic study. It will be used to measure the allowable period for a given diagnostic study, which cannot exceed 20 consecutive days. This date should not be later than the first date shown for hospital plan services in Item 14. Do not show another date, such as the date of the first posting to the hospital record.

Item 12. Patient's Certification and Payment Request. Have the patient or his authorized representative read the statement on the form or the statement in the hospital admission record if the hospital uses the alternate signature procedure (see §§ 270 ff.).

If the hospital obtains the signature on its own form, the signature line of the original of form SSA-1483 should be stamped to indicate that the "Patient's request for payment is on file." If the signature is obtained on form SSA-1483, it is sufficient if it is legible on the original only; a signature is required with each billing. If the hospital obtains a signature on its own record, see § 270.2B for the effective period of the signature.

If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf; e.g., John J. Jones by Jack A. Smith. In certain situations, a hospital representative may sign on behalf of the patient. (See § 271 for who may file a payment request.)

Briefly explain why the patient did not sign the form himself and show the relationship of the signer to the patient. This explanation should be retained in the

hospital's file if the signature is obtained on the hospital's own record. If the signature is on form SSA-1483, the explanation should accompany or be included on the billing form.

The statement should be read to a patient who signs by mark. A signature by mark should be witnessed by a person who knows the patient. Enter the name and address of any person witnessing a signature by mark.

If it is impractical to obtain the patient's signature because he does not himself appear for diagnostic tests (e.g., the physician sent a blood or urine sample to a laboratory of a participating hospital for analysis), the hospital need not obtain the patient's signature. A hospital representative should sign on behalf of the patient and note in Item 12 of the SSA-1483 "Patient not physically present for tests" (see § 271 for additional information).

Item 13. Diagnoses. List here, from the patient's hospital record, the diagnoses of the conditions for which outpatient services were given. If diagnosis is not known, enter "Not Known." Where there are multiple diagnoses in the record, list the primary diagnosis first and enter the word "primary" in parentheses after it.

Check the appropriate block to show whether the condition was employment related. Show the name and address of the employer, if known. Where the hospital knows that a workmen's compensation claim has been made, it should insert or attach a statement identifying the carrier, if any, handling the workmen's compensation claim, and giving any available details about the claim.

Item 14. Statement of Services. For each date given, list the name of all medical procedures—laboratory tests, radium therapy, etc.—performed during the period covered by this billing. List also the name of any operation or endoscopic procedure performed during the billing period. Describe any supplies or equipment furnished.

Medical and surgical procedures other than laboratory tests should be specified in detail using acceptable terminology such as that indicated by the "Current Medical Terminology, Current Procedural Terminology," "Standard Nomenclature of Diseases and Operations," the "American Psychiatric Association's Diagnostic and Statistical Manual," etc.

In completing the statement of services furnished, the hospital should, **to the extent possible**, report laboratory tests by date of each service or inclusive dates of service using the following descriptive categories:

1. Hematology
2. Blood chemistry
3. Virology
4. Serology
5. Urinalyses
6. Clinical microscopy
7. Feces examinations
8. Gastric analysis
9. Spinal fluid exams
10. Sputum exams
11. Tissue studies

For example, a series of blood tests such as a CBC, a hematocrit, and a sedimentation rate for an individual patient would all be reported collectively as "Hematology." Other tests such as EKG, Radioisotopes Audiometric Testing, and Pulmonary Function Studies would need to be specified as would tests not falling into the categories listed.

For x-ray procedures, hospitals should specify the body part involved. It will not be necessary to indicate the number of examinations or the number of plates taken.

In the event the hospital is unable under its present system for outpatient billing to identify services by the descriptive categories, or to specify the body part for x-ray procedures, it may submit bills using currently available identification.

Where a bill is for medical charges only, the hospital should show as many charges as space will permit, even when visits occur on different days. Hospitals with more than one outpatient department should not submit separate billing forms for each, but should bill for services rendered in all departments at the same time.

In the "Charges" columns, show the total charges for each procedure and indicate whether the charge is a medical plan charge, a hospital plan charge, or is a non-covered charge. See § 230.1 for a description of the services covered under each plan.

Where the hospital normally includes a charge for physicians' services in its total charge for a service, the total charges will be billed as usual, and the physician's component will **not** be broken out in noncovered charges. The intermediary will make a deduction for any physicians' charges in arriving at the cost reimbursement. (The physicians' services will be billed for either on the Form SSA-1490, Request for Payment, or on the form SSA-1554, and will be reimbursed on a reasonable charge basis.)

When a posting date for a hospital plan charge occurs more than 20 days after the date shown in Item 11, the intermediary will not assume that the service is

within the same 20-day study period. In this case, the hospital should show the exact dates of services in the Description of Services section.

It may be necessary at times to use more than one outpatient billing form in order that all services rendered an individual are reported on the same billing. When this occurs, Items 1, 2, and 6, as well as 14, should be completed on the additional forms to insure proper identification should the forms become separated. Items 15-18 should be completed **only** on the first form.

Item 15. Summary of Charges.

A. If the hospital is reimbursed by the intermediary on a cost-per-occasion-of-service or cost-per-visit-basis, enter the total number of occasions of service or visits represented by this bill in the "Hospital Plan" and/or "Medical Plan" blocks, as appropriate.

B. Enter the total charges pertaining to each column in Item 14.

Item 16. If physician charges are included in the hospital's charges, they must be excluded in determining the deductible and coinsurance due from the patient. Enter the amounts to be excluded under each plan. These amounts will normally be billed on the SSA-1554 or SSA-1490 as physicians' charges.

Item 17. Subtract the professional component (physicians' charges) from the total hospital and/or medical plan charges. (Item 15B minus Item 16.)

Item 18. Patient Paid. Enter the amounts, if any, paid by the patient or on his behalf for the deductible and/or coinsurance under each plan. Exclude any amount paid by the patient for physicians' services.

Do not use the section to the right entitled "Verified Patient Liability." The intermediary will use this space to enter the total allowable charges which are actually payable by the patient. The intermediary will advise you of the total due from the patient for the deductible and coinsurance.

The remainder of this form, except for Item 22, is for use of the intermediary; however, if the hospital wishes, it may estimate the interim reimbursement amount by either using the hospital copy of the form or a separate piece of paper.

Item 19 is for the intermediary to show the payment computation for outpatient diagnostic studies under the hospital plan.

Item 20 is for the intermediary to show the payment computation for medical and other health services under the medical plan.



**PROVIDER BILLING FOR PATIENT SERVICES BY PHYSICIANS
MEDICAL INSURANCE BENEFITS - SOCIAL SECURITY ACT**

Form Approved,
Budget Bureau No. 72-R747

(Use this form only where the provider has billing arrangement to collect physician charges for individual patient care pursuant to agreement with the physician.)

1. PATIENT'S LAST NAME		FIRST NAME		IM		2. HEALTH INSURANCE CLAIM NUMBER	
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)				4. DATE OF BIRTH		5. SEX <input type="checkbox"/> M <input type="checkbox"/> F	
6. NAME AND ADDRESS OF PROVIDER				7. PROVIDER NO(S)		8. MEDICAL RECORD NO.	

9. ASSIGNMENT: I assign payment for unpaid charges of the physician(s) listed on this form.

AUTHORIZATION: I authorize release of any information required to act on this claim and permit a photographic reproduction of this authorization to be used in place of the original.

The above information is correct. I request payment on my behalf for the medical insurance benefit, if any, payable for the reasonable charges for services described. I understand I am responsible for any medical insurance deductible and 20% of the remaining reasonable charges.

SIGNATURE OF PATIENT (Or his representative)

DATE SIGNED									
10A. DATE OF EACH SERVICE	B. NAME OF PHYSICIAN	C. PLACE OF SERVICE IN, OH, ECF, H	D. FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES	E. DEPARTMENT	F. TOTAL CHARGE WHEN APPLICABLE	G. PERCENTAGE OF TOTAL CHARGE WHEN APPLICABLE	H. CHARGE FOR PHYSICIANS SERVICES	I. LEAVE BLANK	
11. DIAGNOSES AND CONCURRENT CONDITIONS					12. EMPLOYMENT RELATED (If yes, give name and address of employer)				
					<input type="checkbox"/> YES <input type="checkbox"/> NO TOTALS \$				
					Deductible and coinsurance paid				
					Any unpaid balance				

13. PROVIDER CERTIFICATION: The physicians named in item 10B have authorized the provider to accept assignment and receive payments in their behalf (and such authorizations are on file and still in effect.)

SIGNATURE OF PROVIDER REPRESENTATIVE

DATE

Item 21 is for the intermediary to show the treatment of the outpatient diagnostic deductible as an incurred expense under the medical plan.

The intermediary distributes the payment between the patient and hospital, if necessary, taking into account the payments which the hospital received from the patient before the billing form was submitted to the intermediary.

Item 22. Signature of Hospital Representative. Before the billing is forwarded to the intermediary a hospital representative should assure himself that the necessary physician's certification is on file. He should sign his name and show the date. A stamped signature is acceptable.

Item 23. To be completed by the intermediary.

420.2 Disposition of Copies of Completed Forms SSA-1483.—Retain the copy designated "Hospital Copy" and submit the remaining copies to your intermediary (or SSA in direct dealing situations). The remaining copies to be submitted to the intermediary or SSA constitute the following:

a. The original copy which is maintained in the intermediary's (or SSA's) files.

b. Two copies designated "Social Security Administration Copy."

c. The copy designated "Carrier Copy." (This copy serves the same purpose as described under form SSA-1453.)

430. PROVIDER BILLING FOR PATIENT SERVICES BY PHYSICIAN (FORM SSA-1554)

A. This form is used to bill for physicians' services in a hospital where:

1. The beneficiary assigns payment to the physician;
2. The physician agrees that the reasonable charge, as determined by the intermediary, will be the full charge for services rendered; and
3. The physician has authorized the hospital to accept the assignment and collect the payment on his behalf.

Normally the form should be attached to the inpatient or outpatient bill for the stay or services to which the physicians' charges apply. It should be forwarded with the SSA-1453, SSA-1483, or SSA-1485 to your regular intermediary for provider services. Your intermediary will forward it to the carrier for physicians' services with his copy of the regular billing form.

There will be some situations where the SSA-1554 should be submitted directly to the Part B intermediary

without attached hospital billing forms, e.g., all covered hospital days are exhausted in a spell of illness, or a utilization review committee finds that further hospitalization is not necessary but the patient remains in the hospital and receives physician's services which would be billed on an SSA-1554.

Do not use this form if it is your customary procedure to collect the total amount for the physicians' services from the patient. Instead, furnish him with a fully itemized and receipted bill, identifying each physician, his charges, dates of services, and procedures, and inform the patient that he may claim reimbursement by attaching the bill to a Request for Payment (Form SSA-1490).

If, on the other hand, your policy is to collect the amount of the Part B deductible and coinsurance and take assignments on an SSA-1554 billing form for reimbursable amounts, you should complete an SSA-1554 in every case, including situations where total charges for physicians' services do not exceed the deductible amount collected.

Do not use form SSA-1554 to report the services of a physician who wishes the medical insurance payment to be made directly to himself. Inform that physician that he and the patient may complete a Request for Payment (Form SSA-1490) for that purpose.

B. The following is a sample of an authorization for use by providers in connection with provider billing for physicians' services. **A one-time execution of this authorization is all that is necessary by each physician.** The authorization should be retained in the provider's files.

"I hereby authorize the (name of institution) or any of its duly authorized administrators to accept on my behalf any assignment made by any individual who receives medical treatment from me at the (name of institution) of the amount payable to such individual under Part B of Title XVIII of the Social Security Act and to receive on my behalf any payments which may be made pursuant to such assignment. It is understood and agreed that the reasonable charge which will serve as the basis for payment in accordance with the terms of such assignment shall be the full charge for the services."

An additional statement should also include the individual arrangements agreed upon by the provider and the physician governing the conditions of withdrawing the authorization.

430.1 Completing Items on Form SSA-1554.—

Item 1. Patient Identification. The patient's name should be the same as that shown on his health insurance card with the last name first.

Item 2. Health Insurance Claim Number. Enter the health insurance claim number shown on the patient's health insurance card or hospital billing form.

Item 3. Patient's Address. Show the address of the person who is assigning benefits, whether this is the patient or someone acting on his behalf.

Items 4 and 5. Date of Birth and Sex. Complete the "Date of Birth" and "Sex" blocks. If the date of birth is unknown, the hospital should transmit the bill without the date of birth. If only the year of birth is known, but not the month or day, show the year. While the date of birth is useful as identification and should be shown when available, a billing may be processed without the date of birth.

Items 6 and 7. Provider Identification. Enter the name and address of the hospital and the assigned health insurance provider number. These entries may be stamped or preprinted.

Item 8. Medical Record Number. Show the patient's medical record number if one is assigned by the provider.

Item 9. Authorization and Signature. Have the patient or his authorized representative read the statement on the form or the statement in the hospital admission record if the hospital uses the alternate signature procedure (see §§ 270 ff.). If the hospital obtains the signature on its own form, the signature line of form SSA-1554 should be stamped to indicate that the "Patient's request for payment is on file."

If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf, e.g., John J. Jones by Jack A. Smith. In certain situations, a hospital representative may sign on behalf of the patient. (See § 271 for who may file a payment request.)

Briefly explain why the patient did not sign the form himself and show the relationship of the signer to the patient. This explanation should be retained in the hospital's file if the signature is obtained on the hospital's own record. If the signature is on form SSA-1554, the explanation should accompany or be included on the billing form.

The statement should be read to a patient who signs by mark. A signature by mark should be witnessed by a person who knows the patient. Enter the name

and address of any person witnessing a signature by mark.

Item 10A. Date of Service. Show the date for each service when the "item-by-item" method is used to bill for physician charges. Inclusive dates may be shown only where the provider and physician arrange to use the "optional" method to bill such charges (see § 430.3).

Item 10B. Name of Physician. Show the name of the physician for whom the hospital is billing for services. Upon arrangement with the intermediary, billing may be in the name of the hospital department head. This item should be omitted when billing for services by the "optional" method, see § 430.3.

Item 10C. Place of Service. Enter codes "IH" for hospital inpatient, "OH" for hospital outpatient.

Item 10D. Surgical or Medical Procedures. Except where the "optional" method is used in determining physicians' charges, give the surgical, medical laboratory, and x-ray procedures performed for each date during the billing period. The procedures should be clearly identified by the use of standard nomenclature.

Where the "optional" method is used, services are identified on a departmental basis in item 10E and this space is left blank. (See § 430.3.)

Item 10E. Department. Enter the name of the department associated with the physician's services; e.g., x-ray, emergency room, or laboratory.

Items 10F and 10G. Total Charge and Percentage of Total Charge. If the provider and the physician agree to bill for physician charges using the "optional" method, enter in Item 10F the provider's total charges where the charges are combined charges for hospital and physician services shown in Item 10E. Show in Item 10G the approved percentage of the total departmental charge entered in Item 10F. Items 10F and 10G are used only where the "optional" method has been agreed upon by the hospital and physician and approved by the intermediaries (see § 430.3).

Details as to distinguishing the physician charge from costs which are reimbursable to the hospital under the hospital plan are contained in the hospital reimbursement principles.

Item 10H. Charge for Physicians' Services. Enter the money amount attributable to physicians' services. Total all physicians' charges and enter the amount in the "Totals" block. Show any part of the \$50 deductible and coinsurance paid by the patient and subtract the amount paid from the total charges.

Item 11. Diagnosis and Concurrent Conditions. Show the most significant of the conditions first in en-

tering diagnoses. Use recognized nomenclature such as that contained in "Current Medical Terminology, Standard Nomenclature of Diseases and Operations," and the American Psychiatric Associations' "Diagnostic and Statistical Manual," etc. Show any concurrent conditions associated with the primary diagnosis.

In an outpatient case if the diagnosis is not known, show the chief complaint. Where only diagnostic services are rendered, and the diagnosis or chief complaint is not known, show "diagnostic study."

Item 12. Employment Related. Indicate whether the condition is employment related. If the condition is or may be employment related, give the name and address of the employer, if known. Payment may be made subject to reimbursement if a workmen's compensation claim is pending and no settlement is foreseeable.

Item 13. Provider Certification, Signature, and Date. The signature of the hospital representative serves as a request for payment on behalf of physicians. A stamped signature is acceptable. The signature is also a certification that proper authorizations are on file and are still in effect.

430.2 Disposition of Form SSA-1554.—Since this form has only a single copy, the hospital may wish to make a carbon copy when preparing the form, for its own files. The original should be attached to the inpatient or outpatient bill and forwarded to the intermediary for provider services. Where no inpatient or outpatient bill is being submitted, send the form direct to the intermediary for physicians' services.

430.3 Description of "Item-by-Item" and Optional Methods for Physicians' Components.—When the "item-by-item" method is used, the hospital and physicians determine a schedule of separate identifiable charges for each procedure. This schedule is filed with the Part A and Part B intermediaries after agreement is reached with them regarding the appropriateness of all charges. (See § 255.)

A detailed reporting of the surgical or medical procedures is required to enable intermediaries to approve and make payment for physician services under supplementary medical insurance (Part B) in accordance with the schedule of charges established by the provider and physician. Under this method of determining the physician's charge, an itemization of services is necessary.

Under the optional method, the charges for services of a provider-based physician are determined by applying a single uniform percentage of the combined charge for hospital and physician services. The percentage established by the hospital and the physician

must be approved by and filed with the intermediaries and will be used in determining the charge for physician services.

Where the optional method is followed, it will not be necessary for providers to identify the surgical or medical procedure in Item 10D of the Provider Billing for Patient Services by Physicians. It will be sufficient to indicate the department by name, i.e., laboratory, radiology, etc., in Item 10E. The total combined departmental charge for each department and the applicable single uniform percentage must be entered in columns 10F and 10G.

450. PROCEDURE FOR SUBMITTING INPATIENT BILLING IN NO-PAYMENT SITUATIONS

The benefit days available to a beneficiary depend on the status of his utilization of services during the "spell of illness" as described in § 215. Submission of bills by hospitals for all stays, including those for which no program payment can be made, assists the intermediary and the Social Security Administration in maintaining utilization records and determining remaining eligibility.

Hospitals should submit inpatient billing forms in the following situations in which no program payment can be made:

- a. For the period after the date benefits were exhausted;
- b. When services are not covered;
- c. When workmen's compensation paid, or can be expected to pay, the entire bill;
- d. For the period beginning with the fourth day after a utilization review committee finding precludes further payment;
- e. When a National Institutes of Health grant paid or will pay the entire bill;
- f. When the patient or his representative refuses to request that payment be made on his behalf (see § 270);
- g. When the physician refuses to certify for a reason other than lack of medical necessity (see § 273.1).

Only one billing form need be completed for such cases, regardless of the length of time involved, and this form is to be completed after discharge or death. The information to be entered on the billing form is limited to identifying information, critical dates, and essential statistical data.

Completion of Items. When submitting bills falling in categories a through g above, Items 1, 2, 4, 7, 10, 12, 15, 16, 17 (Line O), 18, 22, and 23 are the only

items required on Form SSA-1453, Inpatient Hospital Admission and Billing. Items 1, 2, 4, 7, 10, 13, 16, 17, 18 (Line O), 19, 24, and 25 should be completed on Form SSA-1485, Inpatient Psychiatric and Tuberculosis Admission and Billing.

In Item 24 of form SSA-1453 and Item 26 of form SSA-1485, give the reason for no payment, e.g., Benefits Exhausted, Workmen's Compensation, National Institutes of Health, Noncovered Services, Utilization Review.

Categories f and g above are cases in which utilization is chargeable against the patient, even though no program payment is made. Therefore, a fully completed bill must be prepared. In Item 24 of form SSA-1453 or Item 26 of form SSA-1485, enter "Refused Payment" or "Refused Certification," as the reason for no payment.

If the patient subsequently requests payment or the physician subsequently certifies the medical necessity of the admission, reproduce a copy of the submitted bill. Cross off the entry "Refused Payment" or "Refused Certification" and enter "Patient Requested Payment" or "Physician Certification Obtained."

Covered and Noncovered Days. A hospital may report covered and noncovered days on the same form, but if this is done, all items on the form should be completed, and the charges for noncovered days should be shown in the "Noncovered Charges" column. Only covered days should be shown in the "Total Days" item.

The hospital should, except where benefits have been exhausted, include the appropriate explanation of the reason no reimbursement is being claimed in the "Computation of Interim Payment" item.

460. PROCEDURE FOR SUBMITTING CORRECTED BILLS

The hospital may find that a bill already submitted is incorrect. This might happen, for instance, where late charges were not received at the time of the first billing, or where the patient replaced blood after the first billing.

It is not necessary to submit a corrected bill unless total inpatient charges change by more than \$10, or the interim cost reimbursement by more than \$1. However, a corrected bill should be submitted regardless of the amount of change in charges or cost reimbursement if the number of inpatient days, the inpatient deductible, or the blood deductible is changed.

To correct a previously submitted bill, the hospital should reproduce a legible copy of the submitted bill. The necessary corrections should be made in red in the appropriate item. The corrected bill should be marked "DEBIT—ADJUST" in the upper right margin.

To cancel all the charges on a previously submitted bill, reproduce a legible copy and mark it "CANCEL ONLY" in the upper right margin.

Submit the annotated copy of the bill to the intermediary.

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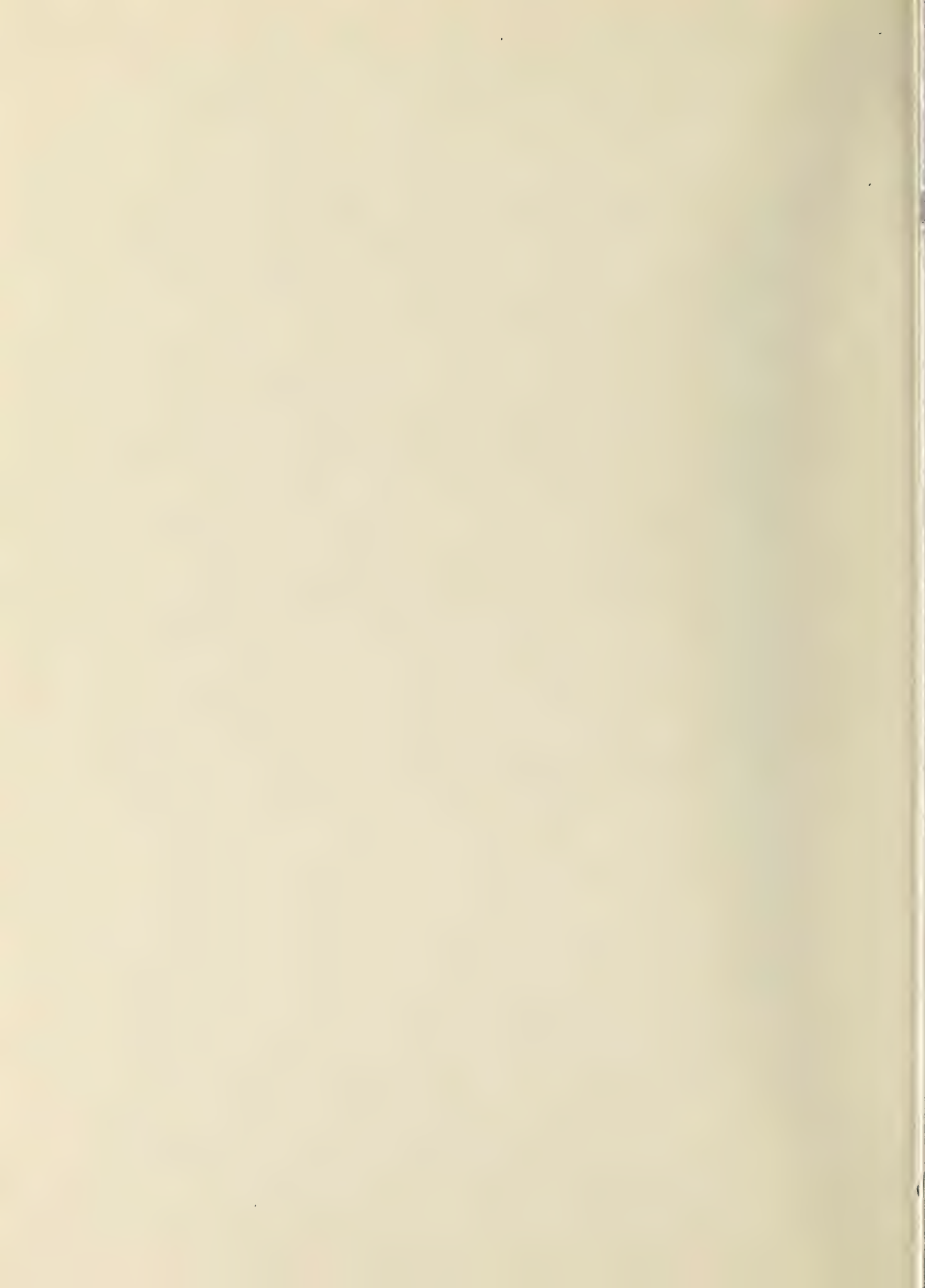
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U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

HOSPITAL MANUAL REVISION

DEPARTMENT OF
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HEALTH INSURANCE FOR THE AGED

SEPTEMBER 1967

NO. 1

<i>New Material</i>	<i>Replacement Pages</i>	<i>Discard Pages</i>
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Section 335, Requests from Extended Care Facilities for Patient Eligibility Information, is new. Extended care facilities will occasionally require ECF eligibility information from hospitals. The hospital should, therefore, routinely include such information on the patient transfer form to the extended care facility. Where the hospital has not included this information on the transfer form, the extended care facility may ask for it.

Section 420.B.3 now lists the health insurance claim number suffixes, J3, J4, K3, K4, M, and M1, which identify beneficiaries entitled to Part B only.

Section 420.1, Completing Items on Forms SSA-1483. The major change is in **Item 15**. Effective January 1, 1968, providers should not use the cost-per-occasion-of-service or cost-per-visit-basis to determine the amount of reimbursement under medicare. Guides are provided to permit intermediaries and providers to arrive at a percentage rate of reimbursement based on the ratio of medicare costs to medicare charges.

The following additional changes have been made:

Item 11. If the bill being submitted contains medical plan charges only, no entry should be made in item 11.





Item 14. Inclusive dates may be used to report therapeutic services, provided that different types of services are reported on separate lines on the billing form.

Item 16. If there are no professional component charges, "0" should be entered in the appropriate block of item 16.

Item 17. If there are no professional component charges, the amount from item 15B should be entered in the appropriate block of item 17.

Thomas M. Tierney, Director
Bureau of Health Insurance

Changed material is indicated in the margin of a page in the following manner:

  = Line on which change begins
or
  = Line on which change ends

Revision transmittal sheets should be filed at the end of the manual as a record of receipt.

Chapter III

ADMISSION PROCEDURES

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as a normal course of hospital procedure to determine the patient's eligibility. However, there will be some situations where, at admission, the individual tells you that benefits have been exhausted in the current spell of illness, or he presents a Notice of Hospital Insurance Utilization which indicates this. The hospital should nevertheless initiate a notice of admission. This notice will serve to verify the information and assure that the patient has in fact no remaining eligibility.

The notice of admission is also essential for processing the billing form to be submitted in accordance with § 450.

Notices of admission should also be initiated where no payments can be made because of the following: Workmen's compensation paid or can be expected to pay the entire bill; services are not covered; the inpatient deductible is not met; the inpatient psychiatric and tuberculosis restriction (§ 217) fully reduces the inpatient benefit days available from 90 to none; payment will be made by a National Institutes of Health grant; or, the patient has refused to request payment.

Where the patient refuses to request payment and does not furnish his health insurance claim number, the hospital should attempt to get the claim number from the social security office. (See § 306.1 for the information that office needs to locate the claim number.)

330. NOTICES OF ADMISSION FOR EMERGENCY SERVICES IN NONPARTICIPATING HOSPITALS

Nonparticipating hospitals will use Form SSA-1453, Inpatient Hospital Admission and Billing as a notice of admission and to bill for covered emergency services. (Use Form SSA-1483, Outpatient Hospital Billing, for emergency outpatient services.) Where a patient is admitted for emergency services (see § 201.1), the admission portion of form SSA-1453 should be completed, and the bottom two copies detached and sent to the social security district office. Items 1 through 14 of the form are to be completed according to § 310.1. The words "EMERGENCY ADMISSION" should be typed, or printed with a ball point pen, in the right-hand portion of Item 12 (Payment Source for Charges to Patient) of the form.

The district office will transmit the admission notice to Social Security Administration central records. (If

the hospital has not been assigned an identification number as a provider qualified to furnish emergency services, the district office will request the SSA regional office to determine the hospital's status and assign an emergency provider number if it qualifies.) A reply to the admission notice giving the patient's eligibility status will be mailed directly to the hospital by the Bureau of Health Insurance, Direct Reimbursement Branch.

When claiming payment, the hospital completes the remainder of form SSA-1453 and sends it, with a copy of the eligibility reply and supporting documentation (see §§ 202 ff.), to the social security district office.

335. REQUESTS FROM EXTENDED CARE FACILITIES FOR PATIENT ELIGIBILITY INFORMATION

In some cases an extended care facility to which the hospital patient is transferred may need information about the patient's entitlement and eligibility for ECF benefits (see § 315, Item G) because there is a question about this, or the reply to the facility's notice of admission is delayed. (There is no guarantee of payment for extended care facilities.)

The hospital should routinely include such eligibility information on the patient transfer form to the ECF to avoid calls for this information. Where the hospital has not included this information on the patient transfer form, the ECF may ask the hospital for it.

399. EXHIBITS

Exhibit 1A. Health Insurance Cards and Claim Numbers.

Exhibit 1B. Certificate of Social Insurance Award.

Exhibit 1C. Temporary Notice of Eligibility.

Exhibit 2. Notice of Hospital Insurance Utilization (Form SSA-1533).

Exhibit 3. Notice of Medical Insurance Utilization (Form SSA-1533A).

Exhibit 4. Inpatient Hospital Admission and Billing (Admission Copy)—Form SSA-1453.

Exhibit 5. Inpatient Psychiatric or Tuberculosis Hospital Admission and Billing (Admission Copy)—Form SSA-1485.

(3) *Patient has a mixture of diagnostic and therapeutic services.* For diagnostic services, charge up to \$20 plus 20 percent of any balance. For therapeutic services, charge the amount necessary to meet the \$50 medical plan deductible (after considering the amount of the diagnostic deductible charge as an incurred expense under the medical plan) and 20 percent of any balance.

(b) *Medical Plan Deductible Is Met.*—Charge 20 percent of the total, whether the services are diagnostic or therapeutic.

2. Patient Has Hospital Plan Entitlement Only.—Only diagnostic services are covered. Charge up to \$20 plus 20 percent of any remainder and the full amount of any charges for therapeutic services.

3. Patient Has Medical Plan Entitlement Only.—(Identified by health insurance claim number suffixes J3, J4, K3, K4, M, and M1.) Both diagnostic and therapeutic services are covered under the medical plan.

Where the deductible is known to be met, charge 20 percent of the total.

Where the deductible is not met or its status is unknown, charge no more than \$50 and 20 percent of any balance. Here the hospital may prefer to wait to bill the patient until the intermediary has verified the deductible status.

C. Billing Examples.—

Example 1: Hospital knows patient has met Part B deductible. Outpatient hospital diagnostic services reasonable charge is \$40. The hospital bills the patient \$8 (20 percent of the total). The intermediary reimburses the hospital 80 percent of the \$20 Part A deductible (\$16), plus 80 percent of the estimated reasonable cost of the services above the \$20 Part A deductible.

Example 2: Patient has met Part B deductible, but hospital has not been able to ascertain that fact. Outpatient hospital diagnostic services reasonable charge is \$40. Hospital bills patient \$24 (the \$20 Part A deductible, plus 20 percent of the remainder).

Intermediary determines by querying SSA central records that Part B deductible had been met. The intermediary reimburses the hospital for 80 percent of the reasonable cost above the \$20 deductible and reimburses the patient \$16 (80 percent of the \$20 Part A deductible).

Example 3: It is uncertain whether the patient has met Part B deductible. Outpatient hospital diagnostic services reasonable charge is \$40. Hospital chooses not to bill the patient until the intermediary has verified the deductible.

The intermediary queries the SSA central record and determines that the patient had not met any part of the Part B deductible. It reimburses the hospital 80 percent of the estimated reasonable cost of the services above the \$20 Part A deductible, and informs the hospital it should bill the patient for \$24, i.e., the Part A deductible, plus \$4 coinsurance.

Example 4: Patient has \$80 in diagnostic services and \$40 in therapeutic services. The hospital believes the medical plan deductible is not met and decides to bill the patient at the same time the billing form is sent to the intermediary.

The hospital bills the patient:

\$20	for the diagnostic deductible;
12	hospital plan coinsurance;
30	medical plan deductible (considering \$20 diagnostic deductible as an incurred Part B expense);
2	coinsurance on the \$10 remaining medical plan charges.
<hr/>	
\$64	Total

420.1 Completing Items on Form SSA-1483.—

Item 1. Patient Identification. Enter the patient's last name, first name, and middle initial from his health insurance card, or other notice.

Item 2. Health Insurance Claim Number. Enter the patient's claim number as shown on his health insurance card, certificate of award, utilization notice, temporary eligibility notice, or as reported by the social security district office.

Item 3. Patient's Address. Show the patient's mailing address from your records. Where the patient's authorized representative is signing the form on behalf of the patient, show the authorized representative's address.

Items 4 and 5. Date of Birth and Sex. Enter the patient's date of birth and sex. If the date of birth is unknown, the hospital should transmit the bill without the date of birth. If only the year of birth is known, but not the month or day, show the year. While the date of birth is useful as identification and should be shown when available, a billing can be processed without the date of birth.

Items 6, 7, and 8. Hospital Identification. Enter the name and address of the hospital and the hospital's assigned provider number. These items can be pre-printed on all copies of this form, if desired. Enter the patient's medical record number only if one is assigned by the hospital for its own filing purposes.

Item 9. Name and Address of Physician Requesting Outpatient Services.—Show the name of the physician who requested outpatient services. Show his address only if your intermediary requires it.

Item 10. Payment Source. Check the appropriate box(es) to identify who will pay any charges that will not be paid for under the health insurance program. This item may be completed either at the time of admission or when billing. More than one source may be checked, if applicable. If the hospital will not bill anyone for expenses not reimbursable under the program, the item need not be completed.

When some or all of the charges are payable under a federally supported assistance program of the Social Security Act, the hospital should identify the public agency in addition to checking the box. Enter the agency's name and address, and the patient's case number, if available. The intermediary may find it necessary to forward a copy of the form to the public agency.

Item 11. Date of First Visit. This date should be the first date on which the patient was seen for the purpose of a 20-day diagnostic study. It will be used to measure the allowable period for a given diagnostic study, which cannot exceed 20 consecutive days. This date should not be later than the first date shown for hospital plan services in Item 14. Do not show another date, such as the date of the first posting to the hospital record. If the bill being submitted contains medical plan charges only, no entry should be made in this item.

Item 12. Patient's Certification and Payment Request. Have the patient or his authorized representative read the statement on the form or the statement in the hospital admission record if the hospital uses the alternate signature procedure (see §§ 270 ff.).

If the hospital obtains the signature on its own form, the signature line of the original of form SSA-1483 should be stamped to indicate that the "Patient's request for payment is on file." If the signature is obtained on form SSA-1483, it is sufficient if it is legible on the original only; a signature is required with each billing. If the hospital obtains a signature

on its own record, see § 270.2B for the effective period of the signature.

If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf; e.g., John J. Jones by Jack A. Smith. In certain situations, a hospital representative may sign on behalf of the patient. (See § 271 for who may file a payment request.)

Briefly explain why the patient did not sign the form himself and show the relationship of the signer to the patient. This explanation should be retained in the hospital's file if the signature is obtained on the hospital's own record. If the signature is on form SSA-1483, the explanation should accompany or be included on the billing form.

The statement should be read to a patient who signs by mark. A signature by mark should be witnessed by a person who knows the patient. Enter the name and address of any person witnessing a signature by mark.

If it is impractical to obtain the patient's signature because he does not himself appear for diagnostic tests (e.g., the physician sent a blood or urine sample to a laboratory of a participating hospital for analysis), the hospital need not obtain the patient's signature. A hospital representative should sign on behalf of the patient and note in Item 12 of the SSA-1483 "Patient not physically present for tests" (see § 271 for additional information).

Item 13. Diagnoses. List here, from the patient's hospital record, the diagnoses of the conditions for which outpatient services were given. If diagnosis is not known, enter "Not Known." Where there are multiple diagnoses in the record, list the primary diagnosis first and enter the word "primary" in parentheses after it.

Check the appropriate block to show whether the condition was employment related. Show the name and address of the employer, if known. Where the hospital knows that a workmen's compensation claim has been made, it should insert or attach a statement identifying the carrier, if any, handling the workmen's compensation claim, and giving any available details about the claim.

Item 14. Statement of Services. For each date given, list the name of all medical procedures—laboratory tests, radium therapy, etc.—performed during the period covered by this billing. List also the name of any operation or endoscopic procedure performed

during the billing period. Describe any supplies or equipment furnished.

Medical and surgical procedures other than laboratory tests should be specified in detail using acceptable terminology such as that indicated by the "Current Medical Terminology, Current Procedural Terminology," "Standard Nomenclature of Diseases and Operations," the "American Psychiatric Association's Diagnostic and Statistical Manual," etc.

In completing the statement of services furnished, the hospital should, *to the extent possible*, report laboratory tests by date of each service or inclusive dates of service using the following descriptive categories:

- | | |
|------------------------|-----------------------|
| 1. Hematology | 7. Feces examinations |
| 2. Blood chemistry | 8. Gastric analysis |
| 3. Virology | 9. Spinal fluid exams |
| 4. Serology | 10. Sputum exams |
| 5. Urinalyses | 11. Tissue studies |
| 6. Clinical microscopy | |

For example, a series of blood tests such as a CBC, a hematocrit, and a sedimentation rate for an individual patient would all be reported collectively as "Hematology." Other tests such as EKG, Radioisotopes Audiometric Testing, and Pulmonary Function Studies would need to be specified as would tests not falling into the categories listed.

For x-ray procedures, hospitals should specify the body part involved. It will not be necessary to indicate the number of examinations or the number of plates taken.

In the event the hospital is unable under its present system for outpatient billing to identify services by the descriptive categories, or to specify the body part for x-ray procedures, it may submit bills using currently available identification.

Where a bill is for medical charges only, the hospital should show as many charges as space will permit,

even when visits occur on different days. Hospitals with more than one outpatient department should not submit separate billing forms for each, but should bill for services rendered in all departments at the same time.

All medical plan services provided should be billed for at the same time charges for a diagnostic study are being reported. Inclusive dates may be used to report therapeutic services, provided that each type of service is reported on a separate line. See the example below where a beneficiary was furnished surgical dressings on several occasions between August 1, 1967, and August 25, 1967, and oxygen was also furnished several times within the same period.

In the "Charges" columns, show the total charges for each procedure and indicate whether the charge is a medical plan charge, a hospital plan charge, or is a noncovered charge. See § 230.1 for a description of the services covered under each plan.

Where the hospital normally includes a charge for physicians' services in its total charge for a service, the total charges will be billed as usual, and the physician's component will *not* be broken down in non-covered charges. The intermediary will make a deduction for physicians' charges in arriving at the cost reimbursement. (The physicians' services will be billed for either on the Form SSA-1490, Request for Payment, or on the Form SSA-1554, and will be reimbursed on a reasonable charge basis.)

When a posting date for a hospital plan charge occurs more than 20 days after the date shown in Item 11, the intermediary will not assume that the service is within the same 20-day study period. In this case, the hospital should show the exact dates of services in the Description of Services section.

It may be necessary at times to use more than one

EXAMPLE OF INCLUSIVE DATE BILLING

14.	DATE OF EACH SERVICE	FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN	TOTAL CHARGES	HOSPITAL PLAN CHARGES	MEDICAL PLAN CHARGES	NON-COVERED CHARGES
	08-01-67					
	08-25-67	Surgical Dressings	25.00		25.00	
	08-01-67					
	08-25-67	Oxygen	18.00		18.00	

outpatient billing form in order that all services rendered an individual are reported on the same billing. When this occurs, Items 1, 2, and 6, as well as 14, should be completed on the additional forms to insure proper identification should the forms become separated. Items 15-18 should be completed *only* on the first form.

Item 15. Summary of Charges.

A. If the hospital is reimbursed by the intermediary on a cost-per-occasion-of-service or cost-per-visit-basis, enter the total number of occasions of service or visits represented by this bill in the "Hospital Plan" and/or "Medical Plan" blocks, as appropriate.

Effective January 1, 1968, the reimbursement rate for outpatient services will always be stated in terms of a percentage, based on the relationship of the hospital's medicare costs to its medicare charges.

Intermediaries will therefore develop a percentage method of reimbursement with all hospitals who now use a cost-per-occasion-of-service or a cost-per-visit method when billing for outpatient services.

The percentage is to be developed on the basis of the provider's most recent cost submission, or on the basis of the provider's actual cost experience projected to the period to be covered by the interim rate.

If allowable costs are 5% less than charges, the reimbursement rate will be 95% of charges.

If allowable costs are 5% more than charges, the reimbursement rate will be 105% of charges.

If a provider's costs as determined by evidence submitted to the intermediary are the same as its charges, the reimbursement rate will be 100%.

If the provider has no charge structure, the normal cost-per-visit or cost-per-occasion-of-service, will be shown as the provider charges. Thus, payment would be made at an interim rate of 100%.

B. Enter the total charges pertaining to each column in Item 14.

Item 16. If physician charges are included in the hospital's charges, they must be excluded in determining the deductible and coinsurance due from the patient. Enter the amounts to be excluded under each plan. These amounts will normally be billed on the SSA-1554 or SSA-1490 as physicians' charges. If there are no professional component charges "0" should be entered in the appropriate block.

Item 17. Subtract the professional component (physicians' charges) from the total hospital and/or medical plan charges. (Item 15B minus Item 16.) If there are no professional component charges, the amount from Item 15B should be entered in the appropriate block.

Item 18. Patient Paid. Enter the amounts, if any, paid by the patient or on his behalf for the deductible and/or coinsurance under each plan. Exclude any amount paid by the patient for physicians' services.

Do not use the section to the right entitled "Verified Patient Liability." The intermediary will use this space to enter the total allowable charges which are actually payable by the patient. The intermediary will advise you of the total due from the patient for the deductible and coinsurance.

The remainder of this form, except for Item 22, is for use by the intermediary; however, if the hospital wishes, it may estimate the interim reimbursement amount by either using the hospital copy of the form or a separate piece of paper.

Item 19 is for the intermediary to show the payment computation for outpatient diagnostic studies under the hospital plan.

Item 20 is for the intermediary to show the payment computation for medical and other health services under the medical plan.



PROVIDER BILLING FOR PATIENT SERVICES BY PHYSICIANS
MEDICAL INSURANCE BENEFITS - SOCIAL SECURITY ACT

Form Approved.
Budget Bureau No. 72-R747

(Use this form only where the provider has billing arrangement to collect physician charges for individual patient care pursuant to agreement with the physician.)

1. PATIENT'S LAST NAME	FIRST NAME	MI	2. HEALTH INSURANCE CLAIM NUMBER		
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)			4. DATE OF BIRTH	5. SEX <input type="checkbox"/> M <input type="checkbox"/> F	
6. NAME AND ADDRESS OF PROVIDER			7. PROVIDER NO(S)		8. MEDICAL RECORD NO.

9. ASSIGNMENT: I assign payment for unpaid charges of the physician(s) listed on this form.

AUTHORIZATION: I authorize release of any information required to act on this claim and permit a photographic reproduction of this authorization to be used in place of the original.

The above information is correct. I request payment on my behalf for the medical insurance benefit, if any, payable for the reasonable charges for services described. I understand I am responsible for any medical insurance deductible and 20% of the remaining reasonable charges.

SIGNATURE OF PATIENT (Or his representative)

DATE SIGNED

10 A. DATE OF EACH SERVICE	B. NAME OF PHYSICIAN	C. PLACE OF SERVICE (H.O.H., E.C.F., H)	D. FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES	E. DEPARTMENT	F. TOTAL CHARGE WHEN APPLICABLE	G. PERCENTAGE OF TOTAL CHARGE WHEN APPLICABLE	H. CHARGE FOR PHYSICIANS SERVICES	I. LEAVE BLANK

11. DIAGNOSES AND CONCURRENT CONDITIONS	12. EMPLOYMENT RELATED (If yes, give name and address of employer)	NO <input type="checkbox"/> YES <input type="checkbox"/>	TOTALS \$
			Deductible and coinsurance paid
			Any unpaid balance

13. PROVIDER CERTIFICATION: The physicians named in item 10B have authorized the provider to accept assignment and receive payments in their behalf (and such authorizations are on file and still in effect.)

SIGNATURE OF PROVIDER REPRESENTATIVE

DATE



U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

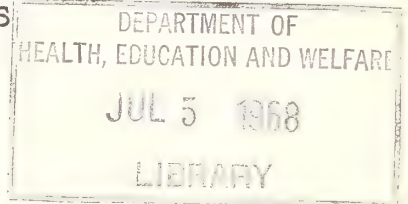
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December 1967

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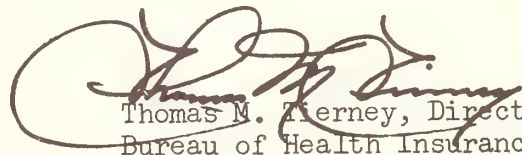
NEW METHOD FOR INTERIM REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES



This transmittal introduces information and procedures for a new method of inpatient reimbursement. A hospital that feels it meets all of the requirements and wishes to be paid under the new method should contact its intermediary.

The material has been prepared as an Addendum and should be filed at the end of the Hospital Manual. A limited distribution of this transmittal has been made directly to hospitals by the Social Security Administration. Intermediaries will complete distribution to hospitals when additional copies are available.

Exhibits 3 and 4, Monthly Summary of Medicare Inpatient Flow and Continuation Sheet, respectively, are draft exhibits. Hospitals participating under this new method will be sent a supply of these forms by the intermediaries as soon as the forms are available.


Thomas M. Tierney, Director
Bureau of Health Insurance

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ADDENDUM FOR HOSPITALS USING THE PERIODIC
INTERIM PAYMENT METHOD OF REIMBURSEMENT

I. SUMMARY OF PERIODIC INTERIM PAYMENT METHOD OF REIMBURSEMENT
AND EFFECTIVE DATE

The periodic interim payment (PIP) reimbursement method for hospital inpatient services is available to all types of participating hospitals meeting these requirements: (1) total medicare payment for inpatient services computed under the new method is at least \$25,000 on an annual basis, (2) the hospital has filed with its intermediary at least one completed cost report under the medicare program, and (3) the intermediary is assured that the hospital has the continuing capability of maintaining in its records the cost charge, and statistical data needed to accurately complete a medicare cost report on a timely basis.

Payment under this method may be made for services furnished on or after January 1, 1968. Any hospital that establishes to the satisfaction of the intermediary that it meets these requirements has the option to request the intermediary to make payments under this method.

The main features of the new method are:

- A. The intermediary will determine a fixed periodic interim payment, generally weekly. (See Section II.) This payment will approximate the cost of the average level of medicare inpatient services rendered by the hospital during the payment interval. The intermediary will disburse these payments on designated days without regard to individual billings from the hospital. A hospital can request that the payment be computed somewhat differently to reflect a significant quarterly variation in medicare utilization. (See Section III.C.)

Payments will be recomputed at regular intervals so that the interim payments will approximate actual costs as closely as possible. (See Section III.D.) In addition, a hospital may at any time request and be allowed an increase in the payment amount where it presents satisfactory evidence for the increase to the intermediary. Likewise, the intermediary will at any time adjust the payment where it has evidence that actual costs or medicare utilization has dropped significantly below the computed rate. (See Section III.F.)

- B. Present medicare inpatient hospital billing forms will continue to be used. A hospital will report admissions of medicare patients to its intermediary under existing procedures. Upon discharge, the hospital will be required to furnish only limited data, including that data needed to update the medicare patient's utilization record. In all cases the hospital

will attach a copy of its regular bill or other form customarily furnished to all patients upon discharge. (See Section VI.C.)

- C. The hospital will complete a Monthly Summary of Medicare Inpatient Flow showing limited information about its medicare inpatient activity during the previous month. This Summary is needed to assure the timely reporting of medicare admissions and discharges to intermediaries, to provide current and continuing indications of the reasonableness of the periodic interim payment amounts and to furnish needed program data. (See Section VI.D.)
- D. As at present, hospitals have to complete the Hospital Statement of Reimbursable Cost for each reporting year.
- E. Hospitals and their intermediaries will continue to have the same relationships under PIP as under other methods of interim reimbursement. From time-to-time, as they now do, intermediaries will visit hospitals to review some of the hospital's records of medicare beneficiaries to verify that the services provided during the period reported to the intermediary were medically necessary covered services. The intermediary will also periodically review the financial and statistical data being accumulated by the hospital to be sure that the data are accurate and sufficient to permit the timely completion of the cost report. The program will rely on the hospital to maintain all of the data pertinent to inpatient services and which are needed to complete the required cost report. The kinds of charge and statistical data are discussed in the instructions for the preparation of the Hospital Statement of Reimbursable Cost (Form SSA-1563) and are largely determined by the method of apportionment (Departmental Method or Combination Method) that the hospital elects as the basis for the apportionment of its costs under medicare. In addition to keeping identifiable charge data for inpatient services and outpatient services, a hospital electing to be reimbursed under the Departmental Method must keep identifiable records of medicare charges and total charges for ancillary services by department. A hospital electing to be reimbursed under the Combination Method must maintain identifiable records of medicare charges and total charges for ancillary services but may do so in the aggregate without regard to any departmental breakdown.

The new method does not require any change in the manner of recordkeeping or the kinds of information the hospital now maintains for medicare purposes providing it yields accurate information under existing requirements. As under present regulations and procedures, cost data must be based on an approved method of cost finding and on the accrual basis of accounting.

Of course, intermediaries will continue to work with hospitals to assure that the hospital's records properly reflect all of the needed cost and charge data. Thus, based on their own cost and statistical data, hospitals will complete cost reports which become the basis for the final settlement, required retroactive adjustment, and required audits.

The PIP method of payment is a significant step toward attaining simplification while maintaining effective and efficient administration. It will result in general improvement and cost savings to hospitals and in program administration. These hospitals paid under the new method will avoid any financial burdens by receiving funds quickly after providing services and can achieve better management through improved financial planning.

Effective Date

An appropriate time to implement this method is the beginning of the hospital's next succeeding reporting year but not earlier than January 1, 1968. However, where a hospital elects to be paid under the new method subsequent to the beginning of its reporting year, it may do so starting at the beginning of any month. This may be done only where the hospital demonstrates to the satisfaction of the intermediary that it has adequate financial and statistical data pertinent to inpatient services and which is needed to support the timely preparation and submission of a complete and accurate cost report covering the hospital's entire current reporting period.

Where a hospital newly participating in the medicare program elects to be reimbursed under the new method the intermediary will evaluate the hospital's ability to meet the criteria for availing itself of the new method, except for the criterion regarding the filing of its initial cost report under the medicare program. The intermediary will submit a report of its evaluation and its decision to SSA.

II. PAYMENT INTERVALS

While the law provides that interim payments shall be made no less often than monthly, experience under the program strongly justifies payment to hospitals at more frequent intervals. Payments are made on a weekly basis unless the hospital at its option, requests the intermediary to make payments at fixed intervals of more than one week but not less often than monthly. Payments on a weekly basis are recommended in order to avoid placing any financial burden on hospitals by providing funds as nearly as possible after the time of providing services.

III. PERIODIC INTERIM PAYMENT COMPUTATION

A. Hospitals With Experience Under the Program

Before making payment under the PIP method, the intermediary will compute the amount per inpatient day which reflects the

hospital's anticipated costs of providing covered services (1) during the forthcoming reporting period where payments under the new method are effective with the beginning of the hospital's reporting year, or (2) during the current reporting period where the intermediary approves the hospital's election to be paid under the new method subsequent to the beginning of its reporting year. Where an intermediary is currently making interim payments on a per diem basis, a projection from the current rate is appropriate.

Some hospitals received prior interim payments on the basis of a percentage of the hospital's charges for services rendered to beneficiaries. In such cases, the intermediary will convert the recent payments made on this basis to the equivalent amount per inpatient day. (Recent payments refer to payments in the immediately preceding 3-month period.) Such a conversion to an amount per inpatient day provides a satisfactory base from which to make a projection of the anticipated costs per inpatient day of providing services during the forthcoming reporting period. The intermediary will also compute a per diem amount representing the deductible and coinsurance amounts which are beneficiary responsibilities. This is best determined from data reported on the most recent Hospital Statistical and Reimbursement Report (HS&R). Hence, the difference between the cost per inpatient day and the deductible and coinsurance amount per inpatient day represents the program responsibility on a per inpatient day basis. The intermediary will project the annual utilization of the hospital's services by medicare beneficiaries based on data from the most recent HS&R report or from the hospital's and intermediary's own records where the intermediary believes a more accurate computation will result.

Hence, the PIP can be computed as follows:

$$\frac{(C - B) \times D}{PI} = \text{PIP}$$

C = cost per inpatient day

B = beneficiary deductible and coinsurance amount per inpatient day

D = projected annual medicare days

PI = payment interval factor

Hospitals would continue to charge and collect from beneficiaries the deductible and coinsurance amounts which are beneficiary responsibilities under the law.

Example A

Hospital A is currently being reimbursed at the rate of \$37 per day. Based on the hospital's most recent HS&R report it

is determined that beneficiary deductible and coinsurance amount per inpatient day is \$3 (Item 8 Inpatient Deductible + Item 9 Inpatient Coinsurance ÷ Item 13 Accommodation Days). The hospital anticipates a 10 percent increase in costs and estimates 4,000 medicare days for the reporting period.

Using the above formula:

$$\frac{(C - B) \times D}{PI} = PIP$$

$$\frac{(\$37.00 + 10\% \text{ of } \$37.00 - \$3.00) \times 4,000 \text{ days}}{52} = PIP$$

$$\frac{\$150,800}{52} = \$2,900$$

Of course, where the hospital requests payment on a bi-weekly or semi-monthly basis the divisor would be 26 or 24, respectively.

B. New Hospitals

When a hospital first enters the program no cost experience will be available on which to base payments. In such cases, the intermediary will use the following methods to determine an appropriate payment:

1. Where there is a hospital or hospitals for which payments have been established and which are comparable in substantially all relevant factors to the new hospital, the intermediary will base the payments to the new hospital on the costs and medicare utilization of the comparable hospital.
2. If there are no substantially comparable hospitals from which data are available, the intermediary will determine a payment based on budgeted or projected costs of the new hospital and estimated medicare utilization of services.

The recomputation of periodic interim payments, as provided hereafter, apply so that adjustments to the periodic interim payment may be based on the latest information available.

C. Alternative Method of Computing Periodic Interim Payments Where There Is a Significant Seasonal Variation in Utilization of Services

Where a hospital's inpatient medicare experience shows significant seasonal variation in utilization of services and the hospital requests PIP payments reflecting this variation in utilization, the intermediary may compute payments accordingly. In no case, however, is the intermediary to

recognize variations in utilization other than on a total quarterly basis starting with the beginning of the hospital's reporting year. The quarterly periods must correspond with the required quarterly recomputation periods.

Example B

Assume all of the facts presented in Example A. In addition the hospital's reporting year under medicare is the calendar year and its records for calendar year 1967 show medicare inpatient utilization as follows: January 1 - March 31, 1967, 35%, April 1- June 30, 1967, 20%, July 1 - September 30, 1967, 15%, October 1 - December 31, 1967, 30%. Accordingly, weekly payments during 1968 could be computed as follows:

$$\begin{array}{l} \text{1st Quarter} \\ \text{PIP} \end{array} = \frac{35\% \times \$150,800}{13} = \$4,060$$

$$\begin{array}{l} \text{2nd Quarter} \\ \text{PIP} \end{array} = \frac{25\% \times \$150,800}{13} = \$2,900$$

$$\begin{array}{l} \text{3rd Quarter} \\ \text{PIP} \end{array} = \frac{15\% \times \$150,800}{13} = \$1,740$$

$$\begin{array}{l} \text{4th Quarter} \\ \text{PIP} \end{array} = \frac{25\% \times \$150,800}{13} = \$2,900$$

Where a hospital requests PIP payments reflecting variations in utilization, its payments for the entire provider reporting year will be computed by the intermediary on this basis. However, the hospital may annually elect to receive payments for each reporting year on a straight line basis or on the basis reflecting variations in utilization where experience shows significant quarterly seasonal variations.

D. Recomputation Following Submission of Cost Report

Immediately after the receipt of the hospital's cost report for the preceding reporting period, the intermediary will recompute the PIP. This will be based on the reported inpatient cost data adjusted for such factors as would appropriately reflect the hospital's estimated cost of providing covered services to beneficiaries for the year following the period covered by the cost report. A projection of the deductible and coinsurance amounts which are the payment responsibility of beneficiaries will also be made by the intermediary and should reflect the appropriate corresponding adjustment factors applied in arriving at the hospital's estimated medicare costs, as well as the bad debt experience

of the provider. For example, assume the average deductible and coinsurance amount charged per medicare patient day during the prior year was \$3.25, 20 percent of the hospital's 10,000 patient days were medicare patient days and two percent of the deductible and coinsurance amounts were bad debts. For the ensuing year, the hospital estimates it will provide 12,000 patient days of care, estimates 20 percent medicare utilization and the same two percent deductible and coinsurance bad debt factor. Based upon these estimates the projected aggregate deductible and coinsurance amount will be:

\$3.25 x 2,400 patient days (2,000 + 20% increase) or \$7,800
less 2% bad debts, or \$7,644

Computation formula:

$$\frac{MC - DC}{PI} = PIP$$

MC = estimated medicare cost

DC = estimated beneficiary deductible and coinsurance payments

PI = payment interval

Example C

Hospital C which receives interim payments on a weekly basis submits its cost report for the preceding accounting year. After cost finding and apportionment in accordance with the Principles of Reimbursement for Provider Costs, it is determined that the cost of the 2,000 medicare inpatient days was \$100,000. For the ensuing year, the hospital estimates a 20% increase in medicare utilization and a 10% increase in costs. In addition, the deductible and coinsurance data in the example contained in the above narrative apply. Converting the aggregate medicare cost to an average cost per diem (for interim payment purposes only) a cost per inpatient day of \$50 (\$100,000 ÷ 2,000 days) is determined. Based on a realistic projection for the ensuing year, a cost of \$55 per day (\$50 + 10% increase) and utilization of 2400 days (2,000 + 20% increase), an estimated annual medicare cost of \$132,000 is computed.

Using the above formula:

$$\frac{MC - DC}{PI} = PIP$$

$$\frac{(\$55 \times 2400 \text{ days}) - (\$3.25 \times 2400 \text{ days less } 2\% \text{ bad debts})}{52 \text{ weeks}} = PIP$$

$$\frac{\$132,000 - \$7,644}{52} = \$2,391$$

E. Alternative Computation of Deductible and Coinsurance Factor (DC) of Formula

An acceptable alternative in projecting the DC factor in the formula would be the deductible and coinsurance payments paid by beneficiaries for the prior period adjusted upward or downward at the rate of \$40 per admission where a realistic change in medicare utilization is projected. For example, assume the deductible and coinsurance amounts collected from beneficiaries in the prior year was \$7500 and the hospital anticipated a 5% increase in medicare utilization, that is, from 2,000 medicare days to 2,100 medicare days. On the basis of the average length of stay for the aged in the hospital, in this example 14 days, an acceptable DC factor in the formula would be \$7,500 plus \$320. (The \$320 represents 100 additional medicare days ÷ 14 days average length of stay for the aged in this hospital x \$40 or 8 x \$40. The conversion of days to admissions should be rounded to the next highest number.)

F. Other Recomputations of Periodic Interim Payments

After the recomputation of the PIP based on cost report data projected, the hospital may at any time request and be allowed an appropriate prospective increase in the PIP, upon presentation of satisfactory evidence to the intermediary that costs or medicare utilization have increased. Likewise, the intermediary may at any time adjust the PIP if it has evidence that the hospital's actual costs or medicare utilization may have fallen significantly below the computed rate. A significant factor in evaluating the amount of the payment in terms of the realization of the projected medicare utilization of services is the timely submission to the intermediary of completed admission and billing forms. (See Section VI.) The intermediary will periodically reconcile the medicare days of utilization based on discharge data as reported on individual forms SSA-1453 or SSA-1485 and the Monthly Summary of Medicare Inpatient Flow with the estimated days of utilization used in computing the PIP payment. Any significant difference will be a factor for the intermediary to consider in making the required recomputations of prospective PIP payments.

Whether or not a hospital requests recomputation, the intermediary will recompute the PIP not less frequently than quarterly. Immediately after receipt of the hospital's cost report the intermediary will recompute the PIP on the basis of reported data without regard to the time interval elapsed

since the immediately preceding recomputation. Following the recomputation based on cost report data, the intermediary will resume its established schedule of recomputations. For example, General Hospital's reporting year ends December 31, 1967, and receives payments from its intermediaries on a weekly basis. It submits its cost report to its intermediary on February 20, 1968. The intermediary will recompute the PIP and make payment based on that report. Thereafter, it will recompute the PIP payment so that revised amounts can be disbursed starting with the first period following March 31, June 30, and September 30.

The overall objective in intermediary surveillance of the periodic payments is to assure payments approximating actual costs as closely as possible.

G. Lump Sum Interim Payments

The intermediary may make a lump sum payment to the hospital to bring past interim payments in line with costs where it has incurred significant expenditures not otherwise reflected in the PIP. Typically, this could occur where retroactive salary increases were disbursed by the hospital. PIP payments should not reflect retroactive costs; they are intended to approximate the actual cost for the payment interval for which they are made.

IV. OFFSETTING OF OUTSTANDING ACCELERATED PAYMENTS ON ACCOUNT

Accelerated payments on account will no longer be needed by any hospital receiving payments under the new method. The intermediary will commence to offset outstanding accelerated payments on account against bills submitted for prior period services and for which an accelerated payment on account had been made. It is expected that the offset will be fully accomplished simultaneously with the conclusion of payment based on individual billings covering services provided before the beginning of the reporting period for which the new method of payment to the hospital is put into effect.

V. REPAYMENT OF CURRENT FINANCING PAYMENT

The disbursement of current financing payments would be no longer required with the implementation of the new method of payment. Outstanding current financing payments should be repaid. Such repayments may be made by a payment from the hospital to the intermediary or on the basis of a reasonable schedule of reductions from the next succeeding PIP payments. In every instance, however, such amount must be fully repaid within 18 months following the receipt by the hospital of its first periodic interim payment under the new method of payment.

VI. HOSPITAL PROCEDURES

A. Notices of Admission

Notices of admission procedures are the same as described in Chapter III, except that the intermediary will identify cases which require the submission of bills showing discharge diagnoses and surgical procedures, (see Section I.B.). Where the Report of Eligibility is the established method of advising the hospital, the remarks section should indicate:

"Show Discharge Diagnoses and Surgical Procedures"
(or other appropriate notation)

All claims where the last digit of the patient's health insurance claim number is "0" or "5" will fall in this category. The admission copies of Forms SSA-1453 or SSA-1485 should be submitted to the intermediary within 24 hours after the patient is admitted.

B. Reporting and Billing Procedures for Patient Stays at Time of Transition or When Straddling Two Reporting Periods

1. Transition to New Method

The PIP method is effective only with services rendered beginning with the hospital's new reporting period but not earlier than January 1, 1968, or the beginning of any succeeding month where the intermediary approves the hospital's election to be paid under the new method. (See Section I.) Hospitals are required to submit Forms SSA-1453 or SSA-1485 covering services rendered through the end of the preceding month and will be paid under existing methods of payment for this period. The billings will be handled as regular interim bills and will be annotated "Still Patient" in item 22 of the SSA-1453 or item 24 of the SSA-1485. Subsequent billings for the same patient will be submitted without sending an additional notice of admission.

2. After Transition to New Method

Where a hospital is already receiving payment under PIP it must submit two billing forms for each medicare patient whose hospital stay straddles the old and new reporting years. This will require each bill to be completed as in C. below, except that the bill covering dates falling in the old reporting period should be annotated "Still Patient" in item 22 of the SSA-1453 or item 24 of the SSA-1485.

C. Completing Items on Billing Forms SSA-1453 and SSA-1485
(See Exhibits 1 and 2)

Completion of the items on the SSA-1453 and SSA-1485 will be the same as under existing procedures except for the following special instructions:

1. Entries in the Statement of Services Rendered items should consist of the following:
 - a. Line E - Total accommodation charges and total non-covered accommodation charges (Line out "Self Care" and enter "Total.")
 - b. Line F - All information
 - c. Line O - Total charges and total noncovered charges
 - d. Line P - Inpatient Deductible
 - e. Line Q - Blood Deductible
 - f. Line R - Coinsurance
2. Discharge or Current Diagnoses and Surgical Procedures items should be completed in all cases designated by the intermediary in the report of eligibility. (See A. above.)
3. Submission of Inpatient Bills

Bills should be submitted at discharge or death. Whenever the patient remains in the hospital a bill should be submitted as of the fourth day after receipt by the hospital of an adverse finding by the utilization review committee, or when benefits are exhausted. In all PIP billings the hospital should attach a copy of the bill or other form that it customarily furnishes to all of its patients at time of discharge. "No payment bills" should be submitted as described in § 450.

Where bills are not submitted on a timely basis the intermediary will reduce prospective payments to conform to a lower level supported by the data shown on the monthly reports.

Corrected bills will be submitted in accordance with § 460 except that correction will be required only where there is a change in any of the reported data.

4. Completion and Submission of Form SSA-1484, Explanation of Accommodation Furnished

The hospital will complete SSA-1484, as described in § 412. If the special deduction described in § 210.1C is applicable, the intermediary will compute the accommodation differential and return the forms to the hospital showing the accommodation differential. The hospital will keep these records for use in preparing its cost report form.

D. Instructions for Completion of Monthly Summary of Medicare Inpatient Flow

a. General Instructions

The Monthly Summary of Medicare Inpatient Flow (MSIF) should be completed by each hospital that is being reimbursed under the periodic interim payment method, and sent on a timely basis to the intermediary with whom it deals monthly. (Where this requirement is not fulfilled, or where actual experience differs significantly from estimates used in arriving at the amount of the fixed payment, the intermediary will at any time adjust prospective payments to a level supported by the data reported on the monthly reports.) The Form should be completed in accordance with the specific instructions below. Each hospital should complete the Form in triplicate. Two copies should be forwarded to the intermediary; the hospital should retain one copy for its files. (See Exhibits 3 and 4.)

Completed forms must be forwarded to the intermediary within 7 days of the end of the month covered by the report. The Form is designed so that much of the information required can be recorded daily rather than monthly if that is more convenient for the hospital.

b. Instructions for Completing Specific Items

Completion of title - Enter the month and year to which the inpatient flow report applies.

SECTION I - IDENTIFYING INFORMATION

1. Hospital identification - Enter on lines 1, 2, and 3 the name, address, and the hospital's assigned health insurance provider number. This may be preprinted on all copies of the hospital's supply of these forms.

2. Intermediary number - The intermediary will enter its assigned health insurance number. This may be preprinted on all copies of these forms.
3. Date forwarded - Enter the month, day, and year that the form is sent to the intermediary.

SECTION II - SUMMARY OF MEDICARE INPATIENTS

1. Inpatient count at beginning of month - Enter the total number of medicare inpatients occupying beds as of mid-night on the last day of the prior month--the month prior to the month shown in the title. Include all persons eligible for medicare benefits even if no payment will be made under the program because the individual has exhausted his benefits, services are not covered, etc.
2. Admissions during month - Enter the total number of persons entitled to medicare benefits admitted to the hospital for inpatient services during the month.
3. Discharges during month - Enter the total number of medicare beneficiaries discharged during the month. Include here patients who died while in inpatient status.
4. Inpatient count at end of month - Enter the number of medicare inpatients occupying beds as of midnight on the last day of the month.

SECTION III - LISTING OF INDIVIDUAL MEDICARE INPATIENTS

Section III of the Form provides census and patient flow information in terms of listings of individual medicare patients. It is possible for the same patient to be listed more than once.

1. Census End of Prior Month - List the health insurance claim number in column (A) and name in column (B) of each medicare beneficiary occupying a bed as of midnight on the last day of the month prior to the month covered by the report, i.e., the month shown in the title. Show the date of admission (month and day) in column (C) for each patient listed. Show in column (D) the date of exhaustion of benefits, where applicable, for each patient listed. Show in column (E) the date of discharge or date of death for each patient listed. Show the date of death only for patients who died while hospitalized. A given patient may be listed only once in Item 1.

2. Admissions During Current Month - List the health insurance claim number, column (A) and name, column (B) of each medicare patient admitted as an inpatient during the month covered by the report, i.e., the month shown in the title. Show in column (C) the date of admission of each patient listed. Show in column (D) the date of exhaustion of benefits, where applicable, for each patient listed. Show in column (E) the date of discharge or date of death of each patient listed. Show the date of death only for patients who died while hospitalized. A given patient may be listed more than once in Item 2. A patient who is listed in Item 1 may also be listed in Item 2. This situation would occur for patients listed in Item 1 who are discharged and readmitted during the current month.

Complete the listing of patients in the "Census End of Prior Month" section before beginning the listing of patients in the "Admissions During Current Month" section. Use as many continuation sheets as necessary. Enter the section captions shown on the Form to identify the group being listed.

The first month for which the Inpatient Flow Form should be prepared is January 1968. The Form should be submitted to the hospital's intermediary by February 7, 1968. The same schedule should be followed each month thereafter. After the first month for which the Form is prepared, the patients listed in Item III-1 of the second month's report should be equivalent to all of the patients in the first month's report for whom no entry appears in column III-E (Date of Discharge). For example, in the report submitted for February 1968, the patients listed in Item III-1 should equal the number of patients for whom no date of discharge was shown in the report for January 1968.



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

INPATIENT HOSPITAL ADMISSION AND BILLING
HOSPITAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

EXHIBIT 1

Form Approved
Budget Bureau
No. 72-R734

1. PATIENT'S LAST NAME			FIRST NAME		MI	2. HEALTH INSURANCE CLAIM NUMBER		
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)						4. DATE OF BIRTH		5. SEX <input type="checkbox"/> M <input type="checkbox"/> F
6. HOSPITAL NAME AND ADDRESS			7. PROVIDER NO.			9. NAME AND ADDRESS OF ATTENDING PHYSICIAN		
			8. MEDICAL RECORD NO.					
10. DATE OF THIS ADMISSION			11. NAME AND ADDRESS OF ANY INSTITUTION FROM WHICH DISCHARGED DURING LAST 60 DAYS (If this hospital, give dates of stay)					
12. PAYMENT SOURCE FOR CHARGES TO PATIENT <input type="checkbox"/> SELF OR FAMILY <input type="checkbox"/> BLUE CROSS BLUE SHIELD <input type="checkbox"/> PUBLIC AGENCY (Give name) <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> EMPLOYER OR UNION <input type="checkbox"/> OTHER (Explain)								
13. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.								
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)							DATE	
14. ADMITTING DIAGNOSIS								
EMPLOYMENT RELATED <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, give name and address of employer								
15. DISCHARGE DIAGNOSES OR CURRENT DIAGNOSES (Primary illness and secondary or complicating illnesses)							Do not use this space	
Complete in 20% of cases *								
16. SURGICAL PROCEDURES (Related to primary illness and other—Show date of each)								
Complete in 20% of cases *								
17. STATEMENT OF SERVICES RENDERED			TOTAL CHARGES		NON-COVERED CHARGES		18. STATEMENT COVERS PERIOD	
ACCOMMODATION	DAYS	RATE					FROM	TO
A. 1-Bed			\$		\$			
B. 2-3-4 Bed								
C. 5 or more Beds								
D. Intensive Care								
E. Self Care TOTAL								
F. WHOLE PINTS FURNISHED	NOT REPLACED	CHARGE PER PINT						
G. Operating Room								
H. Pharmacy								
I. Laboratory								
J. Radiology								
K. Medical, Surgical and Central Supplies								
L. Anesthesia								
M. Inhalation Therapy								
N. Other (Describe)								
O. TOTALS			\$		\$			
P. Inpatient Deductible								
Q. Blood deductible	Pts. @							
R. Coinsurance								
S. TOTAL DEDUCTIONS								
I certify that the required physician's certification and recertifications are on file.								
26. SIGNATURE OF HOSPITAL REPRESENTATIVE			DATE FORWARDED			27. APPROVED BY		
						DATE		
20. DATE GUARANTEE OF PMT. OR UR NOTICE RECEIVED							21. DATE BENEFITS EXHAUSTED	
22. <input type="checkbox"/> DISCHARGED <input type="checkbox"/> DIED <input type="checkbox"/> STILL PATIENT							23. DATE DISCHARGED OR DIED	
24. COMPUTATION OF INTERIM PAYMENT								
(Intermediary enters per diem rate here)								
Reimbursement Amount \$ XXX								
FOR INTERMEDIARY USE								
25. VERIFIED PRIOR STAY DATES							PROVIDER NO.	
FROM TO								
NONE								
27. APPROVED BY							DATE	



DEPARTMENT OF
HEALTH, EDUCATION AND WELFARE
SOCIAL SECURITY ADMINISTRATION

INPATIENT PSYCHIATRIC OR TUBERCULOSIS HOSPITAL ADMISSION AND BILLING
HOSPITAL INSURANCE BENEFITS - SOCIAL SECURITY ACT

EXHIBIT 2
Form Approved
Budget Bureau
No. 72-R732

1. PATIENT'S LAST NAME		FIRST NAME	MI	2. HEALTH INSURANCE CLAIM NUMBER	
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)				4. DATE OF BIRTH	5. SEX <input type="checkbox"/> M <input type="checkbox"/> F
6. HOSPITAL NAME AND ADDRESS		7. PROVIDER NO.		9. NAME AND ADDRESS OF ATTENDING PHYSICIAN	
		8. MEDICAL RECORD NO.			
10. ADMITTED TO ACTIVE CARE		11. NAME AND ADDRESS OF ANY INSTITUTION (including this institution) IN WHICH PATIENT RECEIVED INPATIENT CARE DURING LAST 60 DAYS (If this hospital, give dates of stay)			
12. NAME AND ADDRESS OF ANY PSYCHIATRIC OR TUBERCULOSIS INSTITUTION WHICH FURNISHED INPATIENT SERVICES AT ANY TIME DURING 90 DAY PERIOD PRECEDING EFFECTIVE DATE FOR HOSPITAL INSURANCE (If this hospital, give dates of stay)					

13. PAYMENT SOURCE FOR CHARGES TO PATIENT

- ☐ SELF OR FAMILY
☐ PRIVATE INSURANCE
☐ BLUE CROSS BLUE SHIELD
☐ EMPLOYER OR UNION
☐ PUBLIC AGENCY (Give name)
☐ OTHER (Explain)

14. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.

SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)

DATE

15. ADMITTING OR CURRENT DIAGNOSIS EMPLOYMENT RELATED ☐ YES ☐ NO (If yes, give name and address of employer.)

16. DISCHARGE DIAGNOSES OR CURRENT DIAGNOSES (Primary illness and secondary or complicating illnesses)

Do Not Use This Space

Complete in 20% of cases *

17. SURGICAL PROCEDURES (Related to primary illness and other—Show date of each)

Complete in 20% of cases *

18. STATEMENT OF SERVICES RENDERED				TOTAL CHARGES	NON-COVERED CHARGES	19. STATEMENT COVERS PERIOD FROM	TO	20. TOTAL DAYS
ACCOMMODATION	DAYS	RATE						
A. 1-Bed				\$				
B. 2-3-4 Bed								
C. 5 or more Beds								
D. Intensive Care								
E. S.W.C. TOTAL								
F. WHOLE BLOOD	PINTS FURNISHED	NOT REPLACED	CHARGE PER PINT					
G. Operating Room								
H. Pharmacy								
I. Laboratory								
J. Radiology								
K. Medical, Surgical and Central Supplies								
L. Anesthesia								
M. Inhalation Therapy								
N. Other (Describe)								
O. TOTALS				\$				
P. Inpatient Deductible								
Q. Blood Deductible		Pts. @						
R. Coinsurance								
S. TOTAL DEDUCTIONS								
I certify that the required physician's certification and recertifications are on file.								
28. SIGNATURE OF HOSPITAL REPRESENTATIVE				DATE FORWARDED		29. APPROVED BY		DATE

24. ☐ DISCHARGED ☐ DIED ☐ STILL PATIENT

25. DATE DISCHARGED OR DIED

26. COMPUTATION OF INTERIM PAYMENT

(Intermediary enters per diem rate here)

Reimbursement Amount \$ XXX

FOR INTERMEDIARY USE

27. VERIFIED PRIOR STAY DATES ☐ NONE FROM TO

23. DATE BENEFITS EXHAUSTED

21. DATE ACTIVE CARE ENDED CONTINUING ☐

22. DATE GUARANTEE OF PMT. OR UR NOTICE RECEIVED

FORM SSA-1485 (5-66)

* Complete only where terminal digit of medicare beneficiary's health insurance number is "0" or "5."

A-18

Revision No. 2
12/67

MONTHLY SUMMARY OF MEDICARE INPATIENT FLOW

For _____, 196 _
(Month)

I. IDENTIFYING INFORMATION	II. SUMMARY OF MEDICARE INPATIENTS
1. Name of Hospital: _____	1. Inpatient count at end of last month _____
2. Address of Hospital: _____ _____	2. Plus admissions during month _____
3. Provider Number: _____	3. Less discharges during month _____
4. Date Forwarded to Intermediary: _____	4. Inpatient count at end of month _____
5. Intermediary Number: _____	

III. LISTING OF INDIVIDUAL MEDICARE INPATIENTS

HI Number	Name of Patient	Date of Admission Month / Day	Date of Exhaustion of Benefits Month / Day	Date of Discharge Month / Day
(A)	(B)	(C)	(D)	(E)
1. <u>Census End of Prior Month</u>				
2. <u>Admissions During Current Month</u>				



HEALTH INSURANCE FOR THE AGED

JANUARY 1968

HOSPITAL MANUAL REVISION HIM-10

1968

LIBRARY

NO. 3

New Material

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Replacement Pages

15-17 (3 pp.)
39-40b (8 pp.)
85-86a (3 pp.)

Discard Pages

15-17 (3 pp.)
39-40 (2 pp.)
85-86 (2 pp.)

The principal purpose of this revision is to manualize the recently developed guidelines for applying the custodial care exclusion to care furnished to inpatients of general and psychiatric hospitals. The guidelines applicable to care in tuberculosis hospitals are still under consideration.

Section 261 is the sectional heading assigned to the general subject of custodial care.

Section 261.1 contains the custodial care guidelines for general hospitals.

Section 261.2 contains the custodial care guidelines for psychiatric hospitals.

Section 410.1, Item 16, a reference has been inserted to indicate that documentation is required when the diagnosis on Form SSA-1485 includes certain specified chronic brain disorders, mental deficiencies or psychoneurotic disorders.

The following additional changes have been made:

Section 260.6. Under certain conditions, simple barber and beautician services when furnished by psychiatric and tuberculosis hospitals are covered costs reimbursable under Part A and are not excluded as personal comfort services.

Section 260.11. In connection with the exclusion of services provided by the beneficiary's immediate relatives or members of his household, the meaning of the term "immediate relative" has been clarified.

Thomas M. Tierney, Director
Bureau of Health Insurance

Changed material is indicated in the margin of page in the following manner:

「 」「 」「 」

or

L

= Line on which change begins

= Line on which change ends

Revision transmittal sheets should be filed at the end of the manual as a record of receipt.

Custodial Care

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260.4 Items and services which are not provided within the United States are not covered (except for emergency inpatient hospital services furnished outside the United States under the conditions described in § 202 and payment on behalf of railroad beneficiaries for covered hospital insurance services furnished in Canadian hospitals). The United States includes the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

260.5 Items and services which are required as a result of war, or an act of war, occurring after the effective date of the patient's current coverage are not covered.

260.6 Personal Comfort Items.—Items which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member are not covered.

Charges for special items **requested** by the patient such as radio, television, telephone, air conditioner, and beauty and barber services are excluded from coverage.

Basic personal services such as simple barber, and beautician services (e.g., shaves, haircuts, shampoos, and simple hair sets) which patients need and cannot perform for themselves may be viewed as ordinary patient care when furnished by a long-stay institution. Such services are covered costs reimbursable under Part A when included in the flat rate charge and provided routinely without charge to the patient by a psychiatric or tuberculosis hospital. Maintenance of at least a minimum level of personal hygiene, decency, and presentability is essential to the well-being of the patient himself and of other patients who must associate with him. However, under the personal comfort exclusion, more elaborate services, such as professional manicures, hair styling, etc., are excluded even when furnished routinely and without special charge. The patient may be billed for such services if he requested the service with knowledge that he will be charged a specified amount.

260.7 Routine Physical Checkups; Eyeglasses and Eye Examinations for the purpose of prescribing, fitting, or changing eyeglasses; **Hearing Aids and Examinations for Hearing Aids; and Immunizations** are not covered.

Routine physical checkups include (a) examinations performed without relationship to treatment or diagnosis of a specific illness, symptom, complaint, or injury, and (b) examinations required by third parties

such as insurance companies, business establishments, or Government agencies.

The exclusions apply to eyeglasses or contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors. The exclusions do not apply to services performed in conjunction with an eye disease, as for example glaucoma or cataracts, or to postsurgical prosthetic lenses which are customarily used during convalescence from eye surgery in which the lens of the eye was removed, or to the permanent prosthetic lenses required by an individual lacking the organic lens of the eye, whether by surgical removal or congenital absence. Such prosthetic lens is a replacement for an internal body organ—the lens of the eye. (§ 240.2B2.)

Vaccinations or inoculations are excluded as “immunizations” unless they are directly related to the treatment of an injury or direct exposure such as anti-rabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin.

260.8 Orthopedic Shoes or Other Supportive Devices for the Feet.—The exclusion of orthopedic shoes does not apply to such a shoe if it is an integral part of a leg brace.

260.9 Custodial care is not covered. See § 261 ff. for definition of custodial care and its application to inpatient services.

260.10 Cosmetic Surgery or Expenses Incurred in Connection With Such Surgery are not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, nor to surgery for therapeutic purposes, which coincidentally also serves some cosmetic purpose.

260.11 Charges Imposed by Immediate Relatives of the Patient or Members of His Household are not covered.—The intent of this exclusion is to bar medicare payment for items and services which would ordinarily be furnished gratuitously because of the relationship of the beneficiary to the person imposing the charge.

A. Immediate relative, for the purpose of this exclusion, means spouse, father, mother, son, daughter, brother, or sister—whether by blood **or** marriage **or** adoption. Thus, the following degrees of relationship are included within the definition: (1) Husband and wife; (2) natural parents, children, and siblings; (3) adopted children and adoptive parents; (4) stepparents, stepchildren, stepbrothers, and stepsisters; (5) father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law.

Additionally, the intent of this exclusion extends to a grandparental relationship.

B. Members of the patient's household means those persons sharing a common abode with the patient as part of a single family unit, including those related by blood or marriage, domestic employees and others who live together as part of a single family unit. A mere roomer or boarder is not included.

Where a business enterprise imposes the charge, the exclusion applies, if the firm in fact represents an individual within these relationships. If an individual proprietorship is involved, the proprietor will be considered the individual imposing the charge. Charges imposed by a partnership do not fall within the exclusion unless all of the partners are within the designated relationships to the patient. A corporation is a separate legal entity which cannot be a member of a household or an immediate relative.

260.12 Items and services in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth are not covered. "Structures directly supporting the teeth" means the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth, and alveolar process.

Payment may be made, however, for (a) surgery related to the jaw or any structures contiguous to the jaw, or (b) the reduction of any fracture of the jaw or any facial bone, including dental splints or other appliances used for this purpose.

The hospitalization or nonhospitalization of a patient has no direct bearing on the coverage or exclusion of a given dental procedure. (See also §§ 210.7 and 245 for additional information on dental services.)

260.13 Items and services to the extent that payment has been made, or can reasonably be expected to be made **under a workmen's compensation law** or plan of the United States or a State may not be paid for

by the program. Payments for items and services under the health insurance program are subject to repayment to the appropriate trust fund if notice or information is received that payment has been made for the items and services under a workmen's compensation plan. (See §§ 289 ff.)

260.14 Items or services which the provider is obligated by a law of or because of a contract with the Federal Government to render at public expense are not covered. This exclusion applies to services furnished to veterans pursuant to a contract with the Veterans Administration.

260.15 Items and services are not covered when furnished by a Federal provider of services or other Federal agency except (a) for emergency inpatient hospital services and emergency outpatient hospital diagnosis services furnished by a Federal hospital meeting the requirements of § 202, or (b) when the Federal provider of services is determined by the Secretary of Health, Education, and Welfare to be providing services to the public generally as a community institution or agency.

261 CUSTODIAL CARE

As indicated in § 260.9, custodial care is excluded from coverage under medicare.

261.1 Custodial Care in General Hospitals.

A. Definition.—Custodial care is care designed essentially to assist an individual to meet his activities of daily living—i.e., services which constitute personal care such as help in walking and getting in and out of bed, assistance in bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication which can usually be self-administered—and which does not entail or require the continuing attention of trained medical or paramedical personnel.

Two basic facts must be noted in connection with this definition. **First**, the definition of custodial care does not contemplate an intermediary level of care between covered and custodial care. Accordingly, a decision that an individual is not receiving custodial care is also a decision that the care provided is covered. **Second**, a decision that an individual lacks rehabilitation potential would not necessarily mean that the care furnished him is custodial care. Many patients who have no potential for rehabilitation require a level of care which is covered under the

program. **For example**, a terminal cancer patient whose life expectancy is not more than a few months who requires palliative treatment, periodic "tapping" to relieve fluid accumulation, and careful skin care and hygiene to minimize discomfort is not receiving custodial care. Thus, the controlling factor in determining whether a person is receiving custodial care is the level of care and medical supervision that the patient requires, rather than considerations such as diagnosis, type of condition, or degree of functional limitation.

B. Criteria for Applying Definition of Custodial Care.—Generally, the care furnished an individual requires the continuing attention of trained medical or paramedical personnel if: **First**, the individual's condition medically warrants **skilled services**, and, **Second**, the need for such services constitutes the **primary purpose of the total care** furnished the individual.

1. Skilled Services.—A skilled service is one which **must** be furnished by or under the supervision of trained medical or paramedical personnel to assure the safety of the patient and achieve the medically desired result. A service is not classified as skilled merely because it is performed by a trained medical or paramedical person. A service which can be safely and adequately self-administered or performed by the average, rational, nonmedical person, without the direct supervision of trained medical or paramedical personnel, is a nonskilled service without regard to who actually provides the service. **For example**, a patient, following instructions, can normally take oral medicine. Consequently, giving of oral medicine by a nurse to a patient who is unable to take it himself because of senility would not change the service from a nonskilled to a skilled service.

2. Primary Purpose of Care Furnished.—If the primary purpose of the total care provided an individual is to assist him in meeting the activities of daily living, the custodial care exclusion applies and no payment can be made under the program for any of the care furnished him. However, if the skilled services furnished the patient are the primary purpose for the total care provided, the custodial care exclusion does not apply and payment may be made for services covered under the program.

Where continuing professional nursing services are not necessary, the provision of skilled services to hospital inpatients by other paramedical personnel would not ordinarily justify a finding that such paramedical

services are the primary purpose for the total care furnished a patient. Thus, the determination of whether the primary purpose of the total care furnished is to assist the patient to meet the activities of daily living, or the provision of skilled services, will generally depend on whether the individual's condition requires that the services of a nurse be available to him at all times.

If it is medically necessary to have the services of a nurse available to the patient at all times, the need for this service alone establishes that the primary purpose of the total care is the provision of this skilled service. **For example**, pending stabilization of his condition, the only skilled service a patient with arteriosclerotic heart disease may require is continuing close observation by a trained nurse for signs of decompensation, loss of fluid balance, and the need for adjustment in digitalis dosage. However, since the immediate institution of necessary medical procedures could make the difference between life and death when decompensation is indicated, such observation by trained personnel is absolutely essential to the individual's well-being. The primary purpose of the total care provided this patient is furnishing this skilled service, therefore, the custodial care exclusion does not apply.

When a patient does not require nursing services, the primary purpose of the total care furnished is generally to assist him in meeting his activities of daily living.

Where the need for nursing services is only minimal, the furnishing of skilled services is the primary purpose of the total care furnished only if the range and intensity of all the skilled services furnished in view of the patient's condition, are such that they could not be performed outside the institutional setting. These situations will probably be limited to those where an individual is hospitalized for the running of extensive diagnostic tests.

3. Significance of Physicians' Services.—All physician services rendered to a patient are skilled services. However, even though in an institutional setting the services of a physician may be readily available, generally the physician visits a patient only periodically. He delegates to the nurse the responsibility for keeping, where necessary, close watch for changes in the patient's condition requiring immediate medical action.

Many individuals who require only custodial care may need periodic physician visits for assessment of

their medical status so a medical decision may be made as to whether changes are required in the type of care they are receiving. Nevertheless, periodic visits by a physician to a patient do not change the custodial character of the care when the primary purpose of the total care furnished the patient by the hospital is to assist him to meet his activities of daily living.

(Periodic visits by a physician to his patient are covered under Part B if reasonable and necessary to the treatment of the patient's illness or injury. Such physician services are reimbursable even though a finding has been made that the care furnished the patient in the hospital is custodial and therefore not covered.)

C. Examples of Custodial Care in General Hospitals.—

1. A stroke patient who is ambulatory, has no bladder or bowel involvement, no serious associated or secondary illnesses and does not require medical or paramedical care but requires only the assistance of an aide in feeding, dressing, and bathing.

2. The cardiac patient who is stable and compensated and has reasonable cardiac reserve and no associated illnesses, but who, because of advanced age, has difficulty in managing alone in his home, and requires assistance in meeting the activities of daily living.

3. The senile patient who has diabetes which remains stabilized as long as someone sees to it that he takes his oral medication, and sticks to a prescribed diet.

261.2 Custodial Care in Psychiatric Hospitals.

—The basic principle underlying the provisions for the coverage of inpatient psychiatric hospital services is that payment is to be made by the program only for “active treatment” which can reasonably be expected to improve the patient's condition. To provide assurance that payment is made only under such circumstances, and to preclude the possibility of payment being made for care that is essentially custodial in nature, the law includes certain requirements which must be met before the services furnished in a psychiatric hospital can be covered.

First, the certification that a physician must provide with respect to inpatient psychiatric hospital services is required to include a statement that the

services furnished can reasonably be expected to improve the patient's condition. **Second**, the law provides that payment may be made for these services only if they were being furnished while the patient was receiving either active treatment or admission and related services necessary for diagnostic study. (Thus, the period of time during which an individual receives inpatient psychiatric hospital services which meet the above requirements is, for purposes of the medicare program, considered a **period of active treatment**. Conversely, a patient in a psychiatric hospital who receives services which do not meet the above requirements is, during the period he is receiving such services, considered to be receiving custodial care.) Finally, of course, the law includes a specific exclusion of custodial care which is generally applicable to all kinds of provider services.

Before setting forth the guidelines to be followed in making determinations as to whether the care furnished an individual constitutes active treatment or custodial care, it must be noted that in the context of inpatient psychiatric hospital services emphasis is placed on the presence of “active treatment” and that, therefore, this determination is the crucial one. Simply applying the custodial care definition for general hospitals (§ 261.1A.) would not be sufficient for purposes of determining whether payment may be made since the custodial care definition does not take into account the patient's potential for improvement nor was it designed to permit the more sophisticated judgments required by the concept of active treatment. Consequently, the concept to be applied in rendering determinations with respect to inpatient psychiatric hospital services is the definition of active treatment.

A. Definition of Active Treatment.—The term “active treatment” is defined in a manner designed to reflect and implement the physician certification requirement described above. For services in a psychiatric hospital to be designated as “active treatment,” they must be: (a) provided under an individualized treatment or diagnostic plan, (b) reasonably expected to improve the patient's condition or for the purpose of diagnosis, and (c) supervised and evaluated by a physician. Such factors as diagnosis, length of hospitalization, and the degree of functional limitation, while useful as general indicators of the kind of care most likely being furnished in a given situation, are not controlling in deciding whether the care was active treatment. The following is a discussion of each element of the above definition of active treatment:

1. Individualized Treatment or Diagnostic Plan.—The services must be provided in accordance with an individualized program of treatment or diagnosis developed by a physician in conjunction with staff members of appropriate other disciplines on the basis of a thorough evaluation of the patient's restorative needs and potentialities. Thus, an isolated service, e.g., a single session with a psychiatrist, or a routine laboratory test not furnished under a planned program of therapy or diagnosis would not constitute active treatment, even though the service was therapeutic or diagnostic in nature. The plan of treatment must be recorded in the patient's medical record in accordance with section 405.1037(a)(8) of the regulations on Conditions of Participation for Hospitals.

2. Services Expected to Improve the Condition or for Purpose of Diagnosis.—The services must reasonably be expected to improve the patient's condition or must be for the purpose of diagnostic study. It is not necessary that a course of therapy have as its goal the restoration of the patient to a level which would permit discharge from the institution although the treatment must, at a minimum, be designed both to reduce or control the patient's psychotic or neurotic symptoms which necessitated hospitalization and improve the patient's level of functioning.

The kinds of services which meet the above requirements would include not only psychotherapy, drug therapy, and shock therapy, but also such adjunctive therapies as occupational therapy, recreational therapy, and milieu therapy, provided the adjunctive therapeutic services are expected to result in improvement (as defined above) in the patient's condition. If, however, the only activities prescribed for the patient are primarily diversional in nature, i.e., to provide some social or recreational outlet for the patient, it would not be regarded as treatment to improve the patient's condition. In many large hospitals these adjunctive services are present and part of the life experience of every patient. In a case where milieu therapy (or one of the other adjunctive therapies) is involved, it is particularly important that this therapy be a planned program for the particular patient and not one where life in the hospital is designated as milieu therapy.

In accordance with the above definition of "improvement," the administration of antidepressant or tranquilizing drugs which are expected to significantly alleviate a patient's psychotic or neurotic symptoms would be termed active treatment (assuming that the other elements of the definition are met). However,

the administration of a drug or drugs does not of itself necessarily constitute active treatment. Thus, the use of mild tranquilizers or sedatives **solely** for the purpose of relieving anxiety or insomnia would not constitute active treatment.

3. Services Supervised and Evaluated by a Physician.—Physician participation in the services is an essential ingredient of active treatment. The services of qualified individuals other than physicians, e.g., social workers, occupational therapists, group therapists, attendants, etc., must be prescribed and directed by a physician to meet the specific psychiatric needs of the individual. In short, the physician must serve as a source of information and guidance for all members of the therapeutic team who work directly with the patient in various roles. It is the responsibility of the physician to periodically evaluate the therapeutic program and determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed. Such evaluation should be made on the basis of periodic consultations and conferences with therapists, reviews of the patient's medical record, and regularly scheduled patient interviews—at least once a week.

Although in an institutional setting the services of a physician may be readily available, the general pattern is for the physician to visit the patient only periodically, delegating to nursing personnel the responsibility for intensive observation of patients, where it is necessary. Such periodic visits to a patient do not in themselves constitute active treatment. Conversely, when the physician periodically evaluates the therapeutic program to determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed based on consultations and conferences with therapists, review of the patient's progress as recorded on his medical record and his periodic conversations with the patient, active treatment would be indicated. The treatment furnished the patient should be documented in the medical record in such a manner and with such frequency as to provide a full picture of the therapy administered as well as an assessment of the patient's reaction to it. (See section 405.1037(a)(9) and (10) of the regulations on Conditions of Participation for Hospitals.)

A finding that a patient is not receiving active treatment will not in itself preclude payment for physicians' services under Part B. As long as the professional services rendered by the physician are reasonable and necessary for the care of the patient,

such services would be reimbursable under the medical insurance program.

B. Principles for Evaluating a Period of Active Treatment.—As indicated, the period of time covered by the physician's certification is referred to as a "period of active treatment." This period should include all days on which inpatient psychiatric hospital services were provided because of the individual's need for active treatment—not just the days on which specific therapeutic or diagnostic services were rendered. For example, a patient's program of treatment may necessitate the discontinuance of therapy for a period of time or it may include a period of observation, either in preparation for, or as a followup to therapy, while only maintenance or protective services are furnished. If such periods were essential to the overall treatment plan, they would be regarded as part of the period of active treatment.

The fact that a patient is under the supervision of a physician does not necessarily mean that he is getting active treatment. For example, medical supervision of a patient may be necessary to assure the early detection of significant changes in his condition; however, in the absence of a specific program of therapy designed to effect improvement, a finding that the patient is receiving active treatment would be precluded.

The program's definition of active treatment does not automatically exclude from coverage services rendered to patients who have conditions which ordinarily result in progressive physical and/or mental deterioration. Although patients with such diagnoses will most commonly be receiving custodial care, they may also receive services which meet the program's definition of active treatment. This might be the case, for example where a patient with Alzheimer's or Pick's disease received services designed to alleviate the effects of paralysis, epileptic seizures, or some other neurological symptom, or where a patient in the terminal stages of any disease, received life-supportive care. A period of hospitalization during which services of this kind were furnished would be regarded as a period of active treatment.

C. Documentation Needed for Conditions which Generally Require Custodial Care Only.—In order to expedite the processing of hospital bills and to eliminate the necessity for the intermediary to recontact the hospital for additional information when the diagnosis consists of a condition which ordinarily

results in progressive physical and/or mental deterioration, the hospital bill in such cases must be accompanied by a supplementary explanatory statement. This statement should describe: (a) the specific therapeutic or diagnostic services rendered during the period covered by the bill; (b) the role of the physician in administering such services; and (c) the plan of treatment (or diagnosis) under which the services were rendered. Such a supplementary statement will be required wherever the diagnosis consists of any progressive disabling disease for which custodial services are generally furnished. (In lieu of the statement, a clear photocopy of the patient's medical record and a plan of treatment may be submitted.) This includes the **chronic brain disorders and mental deficiencies** listed under code numbers 10–19 and 60–62 (new nomenclature) of the American Psychiatric Association's *Diagnostic and Statistical Manual, Mental Disorders*. In addition, a supplementary statement showing why hospitalization was necessary for treating the patient should be submitted wherever the diagnosis consists of a psychoneurotic disorder listed under code number 40 in the above manual.

1. Nature of the Diagnosis.—Supplementary information should be submitted routinely wherever the diagnosis recorded on the billing form consists of any progressive disabling disease for which custodial services are generally furnished.

Example: Hospital bill indicates diagnosis of chronic brain syndrome association with trauma. Hospital statement reports that medical record indicates that as a result of a fight in which patient received severe blows to the head, patient suffered brain damage resulting in deterioration of his mental processes and epilepsy. The services for which billing is made include diagnostic evaluation and determining proper treatment for the control of the epilepsy. The plan of treatment indicates that patient will probably receive active treatment for period of 40 to 50 days. Statement is satisfactory, physician's role is implied by reference to plan and result of diagnostic study.

2. The Patient's Prior Hospitalization Record.—The hospital should submit supplementary information whenever the patient's prior hospitalization record, either alone or in combination with other factors, suggests that a period of hospitalization may not have constituted active treatment. For example, where the billing form shows that an individual had been a patient of a psychiatric hospital for a considerable

time, e.g., 60 days or more, before his first day of entitlement, and was admitted to active care shortly after such first day, there would be sufficient basis for submitting supplementary information concerning the stay.

Example: Hospital bill indicates that patient was admitted to active care the second day after he became entitled to hospital benefits. It also indicated that he had been a patient of that same institution for 62 days before being admitted to active care. The provider stated that the patient's medical record indicates that the patient failed to respond to somatic treatment including antidepressants and management of his general physical condition when first admitted to the hospital. A psychiatrist, specializing in work with geriatric patients, was employed by the hospital shortly before this patient became entitled to hospital benefits. The psychiatrist undertook group therapy and an active program designed to involve the patient's family in his care. This therapy is to continue for a period of at least 2 months and may continue for many more. Supplementary information is sufficient to establish provision of active treatment.

3. Ancillary Services Furnished.—Where a hospital itemized ancillary services separately on its bill, the nature and amount of such services would be an important factor to consider in deciding whether the patient was receiving active care. For example, where no ancillary services are listed by a hospital which ordinarily itemizes such services, the hospital should furnish supplementary information showing that active treatment was furnished. On the other hand, the fact that extensive ancillary services are listed would not in itself demonstrate that the services constituted active treatment. The hospital should routinely furnish supplementary information when the bill would not in itself contain sufficient explanation for the intermediary to determine whether active care was furnished.

Example: Hospital bill submitted for patient with schizophrenia, catatonic withdrawal type, indicates patient has been receiving occupational therapy. The last day of active treatment furnished to this patient was 3 weeks before this bill. Since the patient's return to active treatment, particularly to occupational therapy, would raise questions, the hospital submitted supplementary information. The hospital's statement indicated that the patient's medical record showed a resurgence in a youthful interest in music; patient's family purchased a harp for patient which he was re-

learning to play. The return of interest in music made the patient more accessible to individual psychotherapy and to other activity therapies. The plan for this treatment indicated that therapy would be given for a period of 60 days. However, physician's last entry in medical record indicated patient's progress so rapid, he would probably be discharged before 60 days expired. Supplementary statement is sufficient to establish that patient was receiving active treatment.

4. Documentation When Hospital Furnishes Only Intensive Services.—Although an intermediary would be less likely to question the bill of an institution known to furnish only intensive services and which has no custodial patients, than that of a hospital which provides both intensive treatment and custodial care, a supplementary statement should always be furnished where the diagnosis is one which fits any of the disease categories referred to above.

Requirements for Payment

270. REQUEST FOR PAYMENT

Before payment can be made for an inpatient hospital stay, outpatient hospital diagnostic study, hospital services under medical insurance, or physicians' services billed through the hospital, a written request for payment signed by the patient, or by another person qualified to do so on his behalf must be filed. The signature of the patient or other qualified person may be obtained on the respective billing forms, or, under specified conditions, the hospital may obtain a single signature on its records.

If a fully competent and capable patient **refuses** to sign the request for payment necessary for the hospital to obtain reimbursement for the services it furnished, the hospital may charge the patient or other person for the covered services.

270.1 Billing Forms as Request for Payment.—Each of the billing forms (Inpatient Hospital Admission and Billing, Form SSA-1453; Inpatient Psychiatric or Tuberculosis Hospital Admission and Billing, Form SSA-1485; Outpatient Hospital Billing, Form SSA-1483; and Provider Billing for Patient Services by Physicians, Form SSA-1554) contains a patient's signature line incorporating the patient's request for payment of benefits, authorization to release information and assignment of benefits. When the billing form is used as the request for payment, the billing form must be signed. The request for payment will then be forwarded to the intermediary or, to the Social

Security Administration where the hospital deals directly with the Government, when the hospital submits its bill.

A. The billing form as request for payment will be signed in connection **with each inpatient hospital admission**, even though multiple admissions may occur during the same spell of illness. Only one request for payment has to be signed, however, in connection with each inpatient admission, even though an extended hospital stay occasions multiple billings.

B. Where the billing form is used as the request for payment for **physicians' services billed through the hospital for outpatient diagnostic studies and for other outpatient hospital services**, a signature is required with each billing by the hospital.

270.2 Request for Payment on Hospital Record.—In lieu of separate signatures on the billing forms, the hospital may arrange with its hospital insurance intermediary to have the patient's signature on its admission records serve as the request for payment.

The pertinent language on the billing forms must be incorporated, by printing or stamp, either in the hospital's own admission forms, or on a separate form attached to or associated with the hospital's admission form. Where this procedure is adopted, "Patient's request for payment on file" should be stamped on the patient's signature line of the original of the billing form to indicate that the patient's statement is on file.

Item 24. Computation of Interim Payment. Payments to the hospital under the hospital insurance plan are based on the reasonable cost of services provided.

The precise reasonable cost of services cannot be determined until the end of the year when final cost figures are known. An interim settlement is made on the basis of each bill however. This interim settlement method will be established by the intermediary on the basis of the hospital's previous cost experience.

The hospital may wish to make a computation on its own copy of the form. If the hospital wishes to make a computation for its own records it can estimate the cost of covered services by the approved method and subtract the applicable deductible and coinsurance to arrive at the reimbursement amount.

Enter in this item an explanation for any noncovered days shown on the bill. (See Item 19 above and § 450.)

Item 25. Verified Prior-Stay Dates and Provider Number. DO NOT USE.

Item 26. Hospital Certification and Signature Line. A hospital representative should make sure that the required physician's certification and recertifications are in the hospital records. The representative should then sign and date the form before it is submitted to the intermediary. A stamped signature is acceptable. The date forwarded should be the date the bill is actually forwarded to the intermediary. The date used should not be before the "To" date in the "Statement Covers Period" item.

402.2 All-Inclusive Rate Hospitals.—For hospitals using all-inclusive rates, the line for the accommodation actually furnished is to be completed. The number of days, all-inclusive rate, total charges, and noncovered charges must be entered on the bill.

If the patient was furnished more than one type of accommodation, the lines for each type of accommodation are to be completed. This is necessary whether or not the hospital charges an all-inclusive rate according to accommodations.

In hospitals where the all-inclusive rate varies with the type of accommodation, an SSA-1484, Explanation of Accommodation Furnished, should be completed for a medically necessary private accommodation or for five or more bed accommodation. The semiprivate all-inclusive rate should be shown on the SSA-1484.

Item F. Whole Blood. Whenever whole blood is furnished in hospitals using all-inclusive rates, Line F

must be completed. If the all-inclusive rate does not include the charge for whole blood, Line F should be completed in the same way a hospital not using all-inclusive rates would complete this item. Pints furnished, pints not replaced, and charge per pint for the whole blood itself should be shown.

If the all-inclusive rate covers the cost of providing blood whenever a patient needs it, the number of pints furnished, not replaced, and the estimated cost per pint should be entered on line F. It is not necessary to show any amount in the Total Charges column. The cost of any of the first 3 pints which are not replaced should be shown on Line Q. It is not necessary to show the cost for any replaced blood in Item 17.

Item P. Inpatient Deductible. As with hospitals having a schedule of charges for individual services, the amount of any **physician's component** included in the all-inclusive charge should be considered where the exclusion of the physician component would bring the charges below the remaining deductible to be met.

All-Inclusive Charges According to Disease, Injury, or Type of Treatment.—Those hospitals that have a charge system based on the patient's illness or injury or type of treatment should also complete the line(s) for type of accommodation showing number of days, rate, and total charges. The accommodation totals and the total amount (Line O) should be the same. Blood entries will be made in the manner indicated above.

402.3 Disposition of Copies of Completed Forms SSA-1453.—Retain the copy designated "Hospital Copy" and submit the remaining copies to your intermediary (or SSA in direct dealing situations). The remaining copies to be submitted to the intermediary or SSA constitute the following:

a. The original copy which is maintained in the intermediary's (or SSA's) files.

b. One copy designated "Social Security Administration Copy."

c. The copy designated "Carrier Copy." The intermediary will send this copy to the intermediary processing physicians' bills.

410. INPATIENT PSYCHIATRIC OR TUBERCULOSIS ADMISSION AND BILLING (FORM SSA-1485)

The procedures for reporting admissions are described in Chapter III. The hospital fills out Items 1

through 15 of all copies of the form, detaches the bottom two copies, and notifies the intermediary in accordance with its usual procedures. The instructions for using the report of eligibility to determine the number of days for which payment may be made, and any deductibles for which the patient is responsible are contained in § 315.

Items 15 through 26 of the billing form should be completed at the time the bill is rendered. The bill may be rendered at the time the patient is discharged or after his benefits are exhausted. It also may be submitted on an interim basis in long-stay cases.

A billing form should also be submitted even though no program payment can be made—

- a. for periods after benefits are exhausted;
- b. when services are not covered;
- c. for the period after a utilization review finding that services are not medically necessary;
- d. when services are paid for, or can be expected to be paid for, by workmen's compensation;
- e. when services are paid for or will be paid for by a National Institutes of Health grant;
- f. when the patient or his representative refuses to request that payment be made on his behalf;
- g. when the physician refuses to certify for a reason other than lack of medical necessity.

Such bills enable the Social Security Administration and the intermediary to maintain correct current records of deductibles and days available. It is not necessary to complete all the items on a form when there are no covered days. See § 450 for the procedures for completing and submitting this kind of bill.

A hospital bill is also required when the deductible covers the entire amount of the hospital charges. A full bill is completed in these cases.

410.1 Completion of Billing Items on the Form SSA-1485.—

Item 16. Current or Discharge Diagnoses. Enter here all of the diagnoses shown on the face sheet or discharge sheet of the patient's hospital record which relate to the condition requiring the current hospitalization. The primary diagnosis should appear first. This is the diagnosis of the illness or condition which was the primary reason for the patient's hospitalization. Identify this primary diagnosis by writing the word "primary" in parentheses. Any remaining diagnoses

should be listed in the same order in which they appear on the face sheet or discharge sheet. The diagnosis should be shown in accordance with recognized nomenclature, e.g., "Current Medical Terminology," or "Standard Nomenclature of Diseases and Operations."

See § 261.2C for documentation required when diagnosis includes any of the chronic brain disorders listed under code numbers 10-19 (new nomenclature), mental deficiencies under code numbers 60-62 (new nomenclature), or a psychoneurotic disorder under code number 40 (new nomenclature) of the American Psychiatric Association's *Diagnostic and Statistical Manual, Mental Disorders*.

Item 17. Surgical Procedures. Surgical procedures should be specified in detail using recognized nomenclature such as that used in "Current Medical Terminology," "Standard Nomenclature of Diseases and Operations," etc. For the purposes of this form, surgery includes incision, excision, amputation, introduction, endoscopy, repair, destructions, suture, and manipulations.

Enter the name of the procedures, if any, shown on the face sheet or discharge sheet of the patient's hospital record which were performed during the period covered by the bill. Show the dates of each operation or endoscopic procedure listed. List first those procedures related to the primary diagnosis. List all other operation and endoscopic procedures in the same order as is shown on the face sheet or discharge sheet.

Item 18. Statement of Services. Show all charges for the period covered by the current billing for each of the departments. Where your hospital has more departments than shown on the form, combine the charges, where appropriate, for the purpose of completing the form. Where charges for a department not listed on the form are applied to one of the departments listed, all bills submitted should apply the same charges consistently to the same departments. For instance, if Recovery Room is applied to Line G—Operating Room, this should be done on a consistent basis, and should not be listed on Line N—Other—on any bills submitted.

Where there is insufficient space to describe all the services performed in N, Other, it is permissible to combine all other charges. Continuation sheet attachments for charges are not to be used. However, if it is necessary to explain a particular item, this may be done on an attachment.

Machine-Produced Ledger Sheets. Where the hospital wishes to submit machine-produced ledger sheets in lieu of the detailed completion of the Statement of Services item, it may do so if it has been following this practice for other insurance plans. The bill submitted by the hospital should contain departmental totals or subtotals. Hotel-type billing which summarize by day but not by department are not acceptable. Where the days, rate, and type of accommodation are not clear from the machine bill attachment, the hospital will make the accommodation entries. Also, unless

blood furnished, replaced, and charge per pint is shown on the attachment, the hospital should complete Line F, Whole Blood.

Charges for services which are not covered should be fully identified either on the ledger sheet attached or in the "Noncovered Charges" column, unless such charges are routinely billed to all patients per discussion on Total and Noncovered Charges, below.

Any attachments, whether a machine bill or an explanation, should show the patient's name and health

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U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

HEALTH INSURANCE FOR THE AGED

HOSPITAL MANUAL REVISION

HIM-10

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NO. 4

New Material

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This transmittal furnishes hospitals with initial manual instructions on the 1967 Amendments to the Social Security Act.

The material is in the form of chapter supplements and should be inserted at the end of the chapter to which it relates. To facilitate identification, supplements are printed on colored paper. For ease of reference, amendment supplement sections show an "H" prefix and, where practical, the related permanent manual section number has been used. As soon as possible, we will integrate the supplement material in the permanent manual text.

The material included in this transmittal does not cover all of the areas affected by the amendments. As further amendment material is developed, it will be transmitted in supplement form.

The material in this supplement is substantially the same as earlier training and informational materials furnished to the intermediaries which may have been transmitted by them to their hospitals. However, the material should be carefully reviewed since there have been a number of refinements and clarifications. Attention is particularly directed to § H216B concerning the requirements for the beneficiary's election to use lifetime reserve days.

A limited direct distribution of 3 copies of this supplement is being made to each hospital. Intermediaries will complete distribution when additional copies are available.

Thomas M. Tierney, Director
Bureau of Health Insurance

CHAPTER I
1967 AMENDMENTS SUPPLEMENT
GENERAL INFORMATION ABOUT THE PROGRAM

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Hospital Insurance Benefits Entitlement

HI20 B. Transitional Provision.--The 1967 amendments modify the quarters of coverage requirement of the transitional provision. The person attaining age 65 after 1967, who is not entitled to monthly benefits under social security or railroad retirement, will need three less quarters of coverage than under the pre-amendment provision.

Supplementary Medical Insurance Benefits

HI22 A. Enrollment.--The 1967 amendments provide that States will be given the option of "buying-in" for all their aged who are eligible for medical assistance under Title XIX, not just for those receiving cash assistance.

B3 General Enrollment Period.--The first general enrollment period was to occur October 1, 1967, through December 31, 1967. By special Congressional action, however, this period was extended through March 31, 1968. The 1967 amendments provide that effective January 1, 1969, the general enrollment period will be annual rather than biennial and will run from January 1 through March 31 rather than October 1 through December 31. Coverage will begin on the following July 1.

B4 States.--The 1967 amendments extended from January 1968 to January 1970 the deadline before which States may request an agreement with the Secretary to enroll eligible individuals under the "buy-in" provision. States are also permitted to cover under the agreement persons who become eligible for assistance after the agreement date.

HI22.1 Premiums.--Through March 1968, the individual supplementary medical insurance premium was \$3. The law permitted the Secretary of Health, Education, and Welfare to adjust the premium amount if costs should rise, and in December 1967, the Secretary announced a new premium rate of \$4 effective April 1968 through June 1969.

With the 1967 amendments, the law specifies that the Secretary will determine and make known during December of each year the premium rate which will be applicable for a 12-month period to begin the following July 1. When the Secretary makes known a rate change for

Part B, he will issue a public statement setting forth the actuarial assumptions and other bases upon which he arrived at the new rate.

HL22.2 Beginning of Coverage

D. Enrollment by a State of its welfare recipients under the 1967 amendments--coverage begins on the latest of the following:

1. July 1, 1966.(no change)
2. First day of the third month after the month of the agreement with the State. (no change)
3. First day of the first month in which the individual is eligible and a member of the group except that (for a State which buys in for medically indigent persons) if the individual is not in such month receiving money payments under titles I, IV(Part A), X, XIV, or XVI, his coverage will begin on the first day of the second month after such month, or on the first day of the first month in which he receives a money payment under one of the above titles, whichever occurs first. (1967 amendments)
4. The date specified in the agreement.

HL22.3A Coverage Ends.--Prior to the 1967 amendments, an individual could request termination of medical insurance by notifying the Social Security Administration in writing during a general enrollment period and coverage would terminate at the close of the general enrollment period. Because of the extension of the 1967 general enrollment period to April 1, 1968, coverage might end on either December 31, 1967, or March 31, 1968, the effective termination date being determined by the period during which the termination request was filed.

The 1967 amendments provide that beginning April 1, 1968, an individual wishing to disenroll ~~may~~ do so at any time, but such disenrollment will not take effect until the close of the calendar quarter following the calendar quarter in which the notice of disenrollment is filed.

If an individual is enrolled under a Federal-State agreement, his coverage under the agreement ends on whichever of the following occurs first:

1. The end of the month in which he becomes ineligible (as determined by the State) for both welfare money payments or medical assistance (if the agreement covers individuals eligible for medical assistance under title XIX). (1967 amendments)

2. The end of the month before the first month for which he becomes entitled to monthly social security or railroad retirement benefits (if the State's agreement covers only money recipients who are not entitled to such benefits).

3. The end of the month in which the State agreement is terminated.

4. The end of the month in which the individual dies.

CHAPTER II
1967 AMENDMENTS SUPPLEMENT

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COVERAGE OF HOSPITAL SERVICES

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Emergency Hospital Services

H202. DEFINITION OF EMERGENCY HOSPITAL

The amendments provide a new definition of the term "hospital" for purposes of payment for emergency hospital services. The new definition, which will permit additional institutions to qualify as emergency hospitals, is effective July 1, 1966. Therefore, benefits will be payable for emergency hospital services rendered since the program began in such hospitals if the hospital requests payment. Aside from the change in definition of an emergency hospital, all rules in effect before enactment of the amendments will apply to emergency services if the hospital admission took place before January 1, 1968 (additional changes take effect at that time). Emergency outpatient hospital diagnostic benefits furnished prior to 1968 by hospital which meet the new emergency hospital definition will similarly be payable.

The new definition of an emergency hospital requires that the hospital must meet the requirements of the law's definition of a "hospital" relating to full-time nursing services and licensure under State or applicable local law. See § 200 e and g. (A Federal hospital need not be licensed under State or local licensing laws to meet the definition of emergency hospital. This policy applies to claims processed under the prior law as well as those under the amendments.) In addition, the hospital must be primarily engaged in providing, under the supervision of doctors of medicine or osteopathy, services of the type that section 200a describes in defining the term hospital, and must not be primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care. (See the definition of an extended care facility in § 110.2.) Psychiatric and tuberculosis hospitals that meet the above hospital requirements can qualify as emergency hospitals.

The new definition of an emergency hospital is the same definition of "hospital" that will be used henceforth in determining whether an individual has met the 3-day hospital stay requirement for purposes of entitlement to have payment made for posthospital extended care or home health benefits. The new definition for this purpose will apply to hospital discharges occurring on or after January 1, 1968.

H202.1 Payment for Emergency Inpatient Hospital Services.--

Effective for hospital admissions on or after January 1, 1968, nonparticipating hospitals which meet the emergency hospital requirements will be given an opportunity to elect to request payment from the program for all emergency services rendered to beneficiaries in a calendar year. If a hospital so elects, reimbursement will be made to it in accordance with existing procedures for emergency hospital services.

Where the hospital has not elected to bill the medicare program, payment may be made to the beneficiary, based on an itemized bill, for emergency inpatient hospital services. (For earlier emergency hospital admissions where the hospital does not bill the program, the patient may bill the program and receive benefits under the temporary provision applicable to services furnished by nonparticipating hospitals. See § H208.)

If the hospital elects not to request payment from the program, reimbursement will be made to the beneficiary, based on an itemized bill. The reimbursement amount will be equal to 60 percent of the hospital's reasonable charges for routine services plus 80 percent of the reasonable charges for ancillary services for covered days in the spell of illness, subject to the regular Part A deductible and coinsurance. If the hospital does not make separate charges for routine ancillary services, payment will be equal to two-thirds of the hospital's reasonable charges for the services received (not to exceed charges based on semiprivate accommodations), subject to deductible and coinsurance.

"Routine services" means the regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment and facilities for which a separate charge is not customarily made. Charges for semiprivate accommodations or the room occupied, whichever is less, will be the basis for the routine charges allowed. "Ancillary services" means those covered special services for which charges are customarily made over and above those for routine services.

H202.2 Payment for Emergency Outpatient Services.--The hospital's election to request payment from the program applies to emergency outpatient hospital services as well as to inpatient services. Where the hospital has not so elected, payment may be made to the beneficiary, as in the case of inpatient services, for outpatient emergency services furnished on or after January 1, 1968. Reimbursement to the beneficiary will be equal to 80 percent of the hospital's reasonable charge, subject to the applicable deductible and coinsurance.

The amendment provision permitting hospitals to collect in full from the patient certain small outpatient bills applies **only** to participating hospitals. Therefore, emergency outpatient hospital services are not subject to the small outpatient bill procedure.

Until April 1, 1968, outpatient emergency hospital coverage is limited, as under the 1965 law, to outpatient hospital diagnostic services. Such services become covered under Part B as of April 1. Also on April 1, outpatient hospital therapeutic services (hospital services incident to physicians' services rendered to outpatients) become payable in emergency cases when furnished to outpatients by an emergency hospital.

Additional Days of Hospital Care**H216. ADDITIONAL DAYS OF HOSPITAL CARE**

A. General.--The amendments provide that a beneficiary is entitled to have payment made on his behalf for up to 150 days of inpatient hospital services during a single spell of illness minus 1 day for each day of such services in excess of 90 received during any prior spell of illness. Thus, each beneficiary will have a lifetime reserve of 60 additional days of inpatient hospital services to draw upon whenever he has used 90 days of inpatient hospital services in a spell of illness. Payment will be made for such additional days of care unless the individual elects not to have such payments made (and thus save his reserve days for a later time). The amount payable for inpatient hospital services for each of the "reserve" days is reduced by a coinsurance amount of \$20 (one-half of the inpatient hospital deductible). The lifetime reserve provision applies to services furnished after December 31, 1967.

Under the amendments, the guarantee of payment provisions are not applicable until the individual has exhausted his 60 additional days of inpatient hospital services. (See section 286.)

B. Election by Beneficiary.--The beneficiary has the option of electing not to have the program pay for additional days of inpatient hospital services furnished him after he has received benefits for 90 days of such services in a spell of illness. Hospitals are required to notify the beneficiary of his right to make such an election before billing the program for inpatient hospital services furnished after the 90th day in a spell of illness. Hospitals should appropriately annotate their records at the time they inform a beneficiary of this option. Payment may be made for reserve days of services on the basis of the beneficiary's signature on the admission form, unless the patient has indicated specifically by a statement in writing that he does not wish to use any of his reserve days. It follows that a hospital may not charge a beneficiary more than the coinsurance amount for inpatient hospital services furnished after the 90th day of such services in a spell of illness and through the 150th day **unless** it has on record such a statement.

C. Spell of Illness Beginning Before 1968.--Reserve days may be used even where the spell of illness begins before 1968.

1. A beneficiary who has used up 90 days in a spell of illness in 1967 and is still in the hospital during the same spell of illness on January 1, 1968, can use reserve days beginning January 1, 1968.

2. A beneficiary who has used up 90 days in a spell of illness in 1967, leaves the hospital before the end of that year, and returns to the hospital in 1968, in the same spell of illness, may use reserve days as soon as he returns to the hospital.

3. If a beneficiary has used up 90 days before the end of 1967 and is still in the hospital on January 1, 1968, during the same spell of illness, and on such day begins using his reserve days, January 1, 1968 will not be treated as a day of care if he is discharged on that day (reimbursement can be made in accordance with existing rules on day of discharge). If he is not discharged on that day, it will be treated as a day of admission for purposes of counting days of utilization.

D. Availability of Reserve Days.--As a general rule, no reserve day will be counted if the beneficiary is not entitled to have payment made.

Thus, the reserve days are not available to a beneficiary who has been in a psychiatric hospital for the 150 days before the first day of entitlement to health insurance benefits and on the first day of entitlement is still in such hospital.

The reserve days are also not available to a beneficiary who uses up 190 days of inpatient psychiatric hospital care without having used any reserve days and remains in or re-enters a psychiatric hospital. If such a beneficiary needs general hospital services or tuberculosis hospital services, the reserve days will be available to him for such services.

A beneficiary will be deemed to have elected not to use his lifetime reserve to cover inpatient days for which the hospital's daily charge is equal to or less than the coinsurance amount. Such days are treated as noncovered days. For example, reserve days will not be available to a patient of a psychiatric hospital whose daily charge is \$15 (the amount the patient is obligated to pay would remain \$15 regardless of his election). This rule is contrary to the rule which remains in effect for the 61st through 90th day; the beneficiary cannot elect to have such days treated as noncovered days, and in some instances the hospital may be reimbursed for them.

E. Physician Certification.--Physician certification requirements, as modified by the 1967 amendments (see § 273ff.) are applicable to lifetime reserve days.

If a period of time elapses during which the beneficiary remains in the hospital after exhausting his 90 days of benefits and before additional days become covered under the lifetime reserve, the timing of the required certification is determined from the date on which the beneficiary was admitted to the hospital.

For example, Mr. A was admitted to the hospital on December 1, 1967, having previously used 90 days of inpatient hospital benefits in his spell of illness. Since his benefits were exhausted before his 14th day of stay, no physician recertification was made as of that day, nor was there recertification as of the 21st day. The beneficiary becomes entitled on January 1, 1968, to have payment made for up to 60 additional days. Physician certification is then required as of the 51st day of his hospital stay (the 30th day following the 21st day, unless the hospital's utilization review committee has specified that more frequent certifications be made). Thus, if Mr. A remains in the hospital until then, physician certification is required as of January 20.

H216.1 Billing Additional Days.--In replying to the hospital's admission notice, the intermediary will in all cases show the remaining number of lifetime reserve days in the Remarks block of the Report of Eligibility.

When lifetime reserve days are billed, forms SSA-1453 and SSA-1485 will be completed in accordance with existing instructions with the following exceptions:

Coinsurance (Item 17R of SSA-1453 and 18R of SSA-1485) - If both regular and lifetime reserve day coinsurance amounts apply, show only the totals of the two types of days and amounts.

Total Days (Item 19 of SSA-1453 and 20 of SSA-1485) - Show an asterisk after the entry to indicate lifetime reserve days are included.

Computation of Interim Payment block (Item 24 of SSA-1453 and 26 of SSA-1485) - Enter the notation "*Lifetime Reserve Days Used_____".

Below this entry, if more than one coinsurance rate applies, show the days at each rate and total.

EXHIBIT

7. STATEMENT OF SERVICES RENDERED				TOTAL CHARGES		NON-COVERED CHARGES		18. STATEMENT COVERS PERIOD				19. TOTAL DAYS	
ACCOMMODATION	DAYS	RATE						FROM		TO			
A. 1-Bed			\$		\$			01	06	68	01	21	68
B. 2-3-4 Bed													15*
C. 5 or more Beds													
D. Intensive Care													
E. Self Care													
F. WHOLE BLOOD	PINTS FURNISHED	NOT REPLACED	CHARGE PER PINT										
G. Operating Room													
H. Pharmacy													
I. Laboratory													
J. Radiology													
K. Medical, Surgical and Central Supplies													
L. Anesthesia													
M. Inhalation Therapy													
N. Other (Describe)													
O. TOTALS			\$		\$								
P. Inpatient Deductible													
Q. Blood deductible		Pts. @											
R. Coinsurance	15 Days				200	00							
S. TOTAL DEDUCTIONS													
I certify that the required physician's certification and recertifications are on file.													
26. SIGNATURE OF HOSPITAL REPRESENTATIVE				DATE FORWARDED				27. APPROVED BY				DATE	

20. DATE GUARANTEE OF PMT. OR UR NOTICE RECEIVED

21. DATE BENEFITS EXHAUSTED

22. ☐ DISCHARGED ☐ DIED ☐ STILL PATIENT

23. DATE DISCHARGED OR DIED

24. COMPUTATION OF INTERIM PAYMENT

***Lifetime Reserve Days Used 5.**
 $(10 \times \$10)(5 \times \$20) = \$200.00$

Reimbursement Amount \$

FOR INTERMEDIARY USE

25. VERIFIED PRIOR STAY DATES FROM TO

26. PROVIDER NO.

27. DATE

Outpatient Hospital Services
Covered Under Supplementary
Medical Insurance

H230. OUTPATIENT HOSPITAL SERVICES

Effective with services furnished on or after April 1, 1968, coverage of outpatient hospital diagnostic services is transferred from Part A to Part B. Thus, all covered outpatient hospital services, as well as physicians' services to outpatients, will be reimbursable under Part B subject to the \$50 annual deductible and 20 percent coinsurance, and if applicable, the Part B blood deductible. (All special payment provisions previously applicable to outpatient hospital diagnostic services under Part A--the 20 day diagnostic study, \$20 deductible and 20 percent Part A coinsurance--will be eliminated.)

Prior to April 1, 1968, outpatient hospital services are reimbursable only when furnished by or under arrangements made by a participating hospital or when furnished as emergency outpatient hospital diagnostic services by a nonparticipating hospital which meets the definition of an "emergency" hospital. Under the amendments, coverage of emergency outpatient hospital services will include therapeutic as well as diagnostic services. Coverage of nonemergency outpatient hospital services and supplies furnished incident to a physician's service will continue to be limited to those furnished by or under arrangements made by participating hospitals.

The amendments make no change in the scope of outpatient hospital service coverage except as noted in H241 below. Therefore, in determining coverage of a particular item or service furnished to an outpatient, previously established rules (see primarily sections 232 and 240 of the Hospital Manual) should be applied. In general, such coverage includes:

A. Diagnostic Services.--Include all services and supplies in connection with diagnostic procedures (including any drugs and biologicals required in the performance of such procedures) furnished by or under arrangements made by the hospital, if furnished in the hospital or in other facilities or locations under the supervision of the hospital or its organized medical staff. (Independent laboratory services furnished to an outpatient under arrangements with the hospital will continue to be covered only under the "diagnostic laboratory tests" provisions of Part B but may be billed along with other outpatient services.)

B. Hospital Services Incident to Physicians' Services Rendered to Outpatients.--Include services and supplies (including use of hospital facilities) furnished on a physician's order by hospital personnel under hospital medical staff supervision in the hospital or, if outside the hospital, under the personal supervision of a physician who is treating the patient. Drugs and biologicals furnished to outpatients for other than diagnostic purposes are includable only if they are of a type which cannot be self-administered.

Physical Therapy Services Furnished to Outpatients
Covered Under Medical Insurance

H241. OUTPATIENT PHYSICAL THERAPY SERVICES

Effective July 1, 1968, coverage of physical therapy on an outpatient hospital service will be expanded to include services furnished by hospital personnel outside the hospital without personal physician supervision. (See § 240.2A for present coverage of outpatient physical therapy services.)

Coverage under Part B of physical therapy furnished on an outpatient basis will also be expanded by including such services furnished by or under arrangements made by a participating provider of services. For the purposes of this coverage, the term "provider of services" is extended to include approved clinics, rehabilitation agencies, and public health agencies as well as participating hospitals, extended care facilities, and home health agencies. To qualify as providers of services; clinics, rehabilitation agencies and public health agencies will be required to meet certain conditions enumerated in the law and to enter into an agreement with the Secretary in which they agree not to charge any beneficiary for covered services for which the program will pay and to refund any erroneous charges made. Reimbursement for these outpatient physical therapy services will be made to the provider on a cost basis. The patient will be responsible only for the regular Part B deductible and coinsurance amounts (i.e., the annual \$50 deductible and 20 percent coinsurance).

Effective July 1, 1968, coverage of all physical therapy services furnished by hospitals on other providers to outpatients will be subject to the following provisions. Payment would be made for outpatient physical therapy services only where a physician has certified that (1) such services are or were required because the individual needed physical therapy services on an outpatient basis, (2) a plan for furnishing such services has been established and is periodically reviewed by the physician, and (3) such services are or were furnished while the individual is or was under the care of a physician. In addition, the plan of treatment established by the physician must prescribe the type, amount and duration of the physical therapy services to be furnished the individual.

This new provision represents an extension of coverage in that under present law individuals who are not homebound and therefore are ineligible for home health benefits can secure outpatient physical therapy services only if provided as an incident to a

physician's services (i.e., provided under his personal supervision with the charges for such services included in the physician's bill) or as a hospital service furnished incident to a physician's services. Beginning with July 1, 1968, such individuals may secure such services from any provider of services without the requirement that the services be furnished incident to a physician's services. This new provision will also permit a home health patient who runs out of visits to continue to receive covered physical therapy services from the home health agency (or other provider) providing he has Part B coverage.

Instructions as to billing procedures will be issued in the future.

Podiatrists' Services

H245. PODIATRISTS AS PHYSICIANS

Effective January 1, 1968, coverage of physicians' services is extended to include services performed by podiatrists. The intent of the amendments is to allow payment for certain foot care services whether furnished by a doctor of medicine, osteopathy, or podiatry (to the extent that each is legally authorized to perform the services). Certain foot care services (including routine care), however, are excluded regardless of who performs them. (See § H261.)

H245.1 Scope of Coverage of Podiatrists' Services.--Podiatrists (chiroprodists) are included within the definition of "physician" (except as indicated in H245.2 but only with respect to those functions which they are legally authorized to perform in the State in which they perform them. This means that the professional services provided by a podiatrist within the scope of his applicable State license (except those services which are specifically excluded) are "physicians' services," reimbursable on a reasonable charge basis under Part B.

Podiatrists may hold any of the following professional degrees, of which the first three are the most common: Pod.D. or D.P. (Doctor of Podiatry), D.S.C. (Doctor of Surgical Chiropody), D.P.M. (Doctor of Podiatric Medicine), D.S.P. (Doctor of Surgical Podiatry), Graduate in Podiatry, Master Chiroprodist, or in a very few instances another podiatry degree. Within a particular State, all individuals holding any of these degrees are licensed to perform the same functions; however, there are variations from State to State as to the authorized scope of podiatric practice.

A. Provider-Based Podiatrists' Services (§ 255).--Some podiatrists render services as employees of or under arrangements with hospitals; these services have been reimbursed as provider services on a reasonable cost basis under the 1965 law. Under the amendments, however, podiatrists are "physicians" and therefore their professional services for individual patients are reimbursable only on a reasonable charge basis as "physicians' services" under Part B. Hospitals will not be able to include payments made to podiatrists for such services (rendered on and after 1/1/68) as part of their allowable costs (regardless of whether the podiatrist's professional services are covered under Part B). The covered services in a hospital setting of those podiatrists who already have financial arrangements, with hospitals, as well as those who subsequently establish such arrangements, will

be subject to the principles of reimbursement for hospital-based physicians. (See § 255 and the regulations concerning the Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians §§ 405.480 - 405.488.)

B. Interns and Residents (§ 236C).--A few hospitals have podiatry internship and residency programs. Such podiatry teaching programs are not included in the statute's enumeration of "approved" teaching programs whose costs are reimbursable under Part A. Therefore, services of podiatry interns and residents will be subject to the principles governing reimbursement for the services of interns and residents who are not under approved teaching programs, i.e., such services are reimbursable to the hospital on a reasonable cost basis under Part B. The services of podiatry interns and residents are not reimbursable on a reasonable charge basis even though such individuals may be legally authorized to practice as podiatrists.

H245.2 Services for Which Podiatrists Are Excluded From the Definition of Physician.--

A. Physician Certification and Recertification of the Need for Provider Services (§ 273).--A podiatrist is not a "physician" for the purpose of making the required physician certifications and recertifications of the medical necessity for Part A and Part B provider services. This means that a medical doctor (or osteopath) must complete the certification of necessity for provider services where such certifications are required. (See section H273.) However, no certification by a medical doctor is required with respect to a podiatrist's professional services to his patients.

B. Utilization Review (§ 290).--A podiatrist is not a "physician" for the purpose of serving in the capacity of one of the two "physician" members required for hospital and extended care facility utilization review committees. He is not prohibited, however, from serving in the capacity of a nonphysician member. Final utilization review determinations of medical necessity for the full range of provider services should be made by "physicians" who are competent to assess a patient's total medical care situation. However, in the case of a podiatric patient, it is expected that the utilization review committee would consult with the podiatrist as well as the certifying physician before making a determination that further inpatient care is not medically necessary.

H245.3 Coverage of Services and Supplies Incident to the Services of Podiatrists (§ 240.2).--Established policies for determining when supplies and services are covered as incident to a physician's services in his office, a clinic, or a hospital outpatient department generally apply. However, services and supplies are covered under this provision only if they are incident to covered professional services. Further, the incidental items and services themselves should be carefully evaluated to determine whether they fall within the foot care exclusions, particularly services which may be in connection with corrective footwear and routine hygienic care. (See section H261.1 for instructions concerning application of the foot care exclusions to provider services with particular reference to outpatient hospital services.)

Radiological and Pathological ServicesH255. RADIOLOGICAL AND PATHOLOGICAL SERVICES TO HOSPITAL
INPATIENTS

Effective April 1, 1968, reimbursement will be made under Part B for the full reasonable charge for radiological and pathological services furnished to inpatients of a qualified hospital, that is, a hospital which meets all of the medicare conditions of participation, by a physician in the field of radiology or pathology. This means that 100 percent reimbursement will be made for the reasonable charges for such services, subject to neither the usual deductible nor coinsurance features of Part B. Expenses incurred under this provision of the 1967 amendments will not count toward the fulfillment of the regular \$50 Part B deductible.

A. Billing for Radiological and Pathological Services to Hospital Inpatients.--Where the physician has authorized the hospital to bill on his behalf, it will not be necessary on a patient-by-patient basis to break down the bill into professional and hospital components. (The current procedures on authorization by physicians for providers to accept assignment and receive payments on their behalf apply to this new provision of the law.) Reimbursement for the combined charge will be made to the hospital on an interim basis by the Part A intermediary from the Part A funds. Adjustments between the Part A and Part B trust funds will be made on the basis of audited costs.

On the other hand, where a claim is made for the professional component, reimbursement for professional services is made from Part B funds by the Part B carrier; thus, no adjustment between the trust funds is necessary. As in the past, reimbursement for the hospital component of these services will be made by the Part A intermediary. The physician may, if he so chooses, accept assignment and submit a single bill to the program for the full reasonable charge for his professional services. In such cases, the physician would not have to look to the patient for additional payment. If the physician bills the beneficiary without accepting an assignment, the beneficiary will receive reimbursement from the program for the physician's full reasonable charge. The hospital and the physician are free to decide whether the charges for the physician's services are to be billed by the hospital or by the physician, as well as to determine the additional elements of the parties' financial arrangements with each other.

B. Field of Radiology or Pathology.--A physician in the "field of radiology or pathology" includes not only a specialist in one of those fields, i.e., a radiologist or pathologist, but also a physician who normally performs or supervises the radiological or pathological services for patients of a particular hospital, even though the physician does not otherwise specialize in radiology or pathology. An example of this situation is a small hospital which has no radiologists but designates another physician to handle or supervise the hospital radiological procedures. The full reasonable charge for the radiological services of this physician rendered in such a capacity would be covered. On the other hand, the reading of an x-ray film as part of his usual services for his own patients by, for example, an attending physician or surgeon would normally be covered only as regular physicians' services, i.e., the basis for reimbursement would be 80 percent of the reasonable charge, subject to the \$50 deductible.

Exclusion of Refractive Services

H260.7 Exclusion of Eye Care Services.--Effective January 1, 1968, the amendments expand the scope of the eye care exclusion contained in the present law by also excluding from coverage procedures performed during the course of any eye examination to determine the refractive state of the eyes. Thus, expenses for all eye refraction procedures, whether performed by an ophthalmologist (or any other physician) or by an optometrist and without regard to the reason for the performance of the refraction, are excluded from coverage under the program.

Exclusion of Foot Care

H261. EXCLUDED FOOT CARE SERVICES

The amendments limit the scope of covered foot care services by excluding the following types of services under both Part A and Part B, effective January 1, 1968.

A. Treatment of Flat Foot Conditions and Prescription of Supportive Devices Therefor.--For the purposes of this exclusion, treatment of "flat foot conditions" means treatment of the local condition of flattened arches regardless of the underlying pathology causing it, except where such treatment is purely incidental to and an integral part of covered foot treatment (for example, treatment of a fracture). The term "treatment" encompasses all phases of services in connection with flat feet, including evaluations as well as any measures or devices designed either to correct the condition or to palliate pain and other symptoms associated with the condition.

B. Treatment of Subluxations of the Foot.--For the purposes of this exclusion, the term "subluxation" refers to structural misalignments of the feet (except fractures and complete dislocations) which do not require treatment by surgical methods, regardless of the underlying pathology. Excluded "treatment" of the above conditions includes evaluations as well as the nonsurgical measures, supplies, or appliances used to correct the condition or alleviate symptoms. The exclusion does not apply where such treatment is purely incidental to and an integral part of covered foot treatment (such as treatment of a fracture) or where performed as a part of postoperative care during the period of convalescence from covered foot surgery.

This exclusion does not apply to the ankle joint (talo-crural joint).

C. Routine Foot Care.--Routine foot care includes the cutting or removal of corns, warts, or calluses, **the trimming of nails**, and routine hygienic care. "Routine hygienic care" includes hygienic and preventive maintenance care of the feet, of the type which is ordinarily considered self-care, such as observation and cleansing of the feet, use of skin creams to maintain skin tone of both ambulatory and bedfast patients, nail care not involving surgery, prevention and reduction of corns, calluses and warts, and any services performed in the absence of localized illness, injury, or symptoms involving the foot.

The above types of "routine" care are excluded regardless of the reason for such care. Thus, the fact that a particular individual is unable to perform certain care for himself (for example, because of a physical disability or a predisposing systemic disease such as diabetes or peripheral vascular disease which makes preventive hygienic foot care particularly important) does not change the character of the services and make them "nonroutine." Hygienic and other care which is simply incident to and an integral part of active covered treatment of foot lesions, such as infections and diabetic ulcers, is not considered as "routine" care and hence is not excluded.

H261.1 Application of Foot Care Exclusions to Provider Services.--
Charges for provider services furnished in connection with non-covered foot care which are normally separately identified by the provider must be shown as noncovered charges. However, the provider need not identify services in connection with noncovered foot care where it is neither the normal practice to separately identify the services nor administratively feasible to establish a separate charge for such services, or where such services are performed only incidentally at the same time as and as a necessary integral part of a primary covered procedure. In addition, where services or procedures are performed in connection with the diagnosis of specific symptoms or complaints which require covered services, the initial diagnostic services are covered services regardless of the resulting diagnosis.

Where a patient who is receiving covered hospital services also receives noncovered foot care services (e.g., routine hygienic foot care included as a regular part of the nursing care) and a separate charge is not made for such services, it would not be necessary to compute and exclude that portion of the hospital's charge which is attributable to the noncovered foot care. If, however, the patient receives inpatient or outpatient hospital services for the purpose of noncovered foot care (e.g., surgical removal of a wart on the foot), all of the hospital services received by the patient can be attributed to noncovered services and hence must be excluded from coverage.

An exception to this latter rule may be made where a doctor of medicine or osteopathy certifies that hospitalization is required for proper medical management of a systemic disease during non-covered foot treatment. In such cases, the inpatient hospital services, including all ancillaries, may be covered even though no payment may be made for the professional services performed by the podiatrist or other physician in connection with the foot care.

It is expected that the foot care exclusions will have greater application to outpatient hospital services than to inpatient services. For example, in the outpatient department it is more likely that the total services received on an occasion can be attributed to noncovered foot care and hence excluded (as in the case of outpatient surgical removal of a wart). In an outpatient situation it is also more likely that separate itemization of charges for noncovered foot care not integrally related to a covered procedure may be the usual practice, thereby permitting exclusion of such charges (as in the case of a separate excludable charge for routine foot care furnished as a hospital service as part of followup visits to a diabetic clinic).

Physician Certification and Recertification

H273. CERTIFICATION AND RECERTIFICATION BY PHYSICIANS--GENERAL
The amendments eliminate the requirement for certification by a physician as to the need for admission in the case of inpatient hospital services as well as the requirement for a physician's certification for outpatient hospital services. (The physician certification requirement is, however, retained for some outpatient services, such as ambulance service.) As under the prior law, the amendments provide that, where inpatient hospital services are furnished over a period of time, a physician's certification as to the need for continued stay would be required, in accordance with criteria to be set forth in regulations. (For purposes of the requirements with regard to the need for continued stay, the amendments use the term "certify" whereas the prior law used the term "recertify.") All other physician certification and recertification requirements have been retained.

The amendments also provide that a doctor of podiatry or surgical chiropody is not a "physician" for physician certification and recertification purposes. (The amendments add to Part B the coverage of nonroutine services of doctors of podiatry or surgical chiropody.) Where covered provider services are furnished to the patient of a podiatrist, the required certification and recertification statement can be prepared only by a physician who is permitted to do so, that is, a doctor of medicine or osteopathy or, in certain circumstances, a doctor of dentistry or of dental or oral surgery.

Except as indicated below, hospitals and other providers of services will continue to obtain physician certification and recertification statements in accordance with existing provider manual instructions.

H274. INPATIENT HOSPITAL SERVICES CERTIFICATION

The requirement for certification as to the need for inpatient admission is eliminated with respect to patients admitted to the hospital on or after January 3, 1968. Where inpatient hospital services are furnished over a period of time, the hospital must obtain statements in accordance with the existing manual instructions on physician recertification (sections 275 and 276). Accordingly, an initial certification statement must be obtained as of the 14th day of hospitalization, a second statement as of the 21st day, and subsequent statements in accordance with intervals established by the hospital utilization review committee, but not exceeding 30 days. (See § H216 for application of the certification provisions to lifetime reserve days.) The certification statements

must contain the same information called for by the existing recertification instructions, that is, the reasons for and estimated period of continued hospitalization and any plans, where appropriate, for posthospital care.

(There is no change in the physician certification and recertification requirements for inpatient psychiatric and tuberculosis hospital services. Thus, psychiatric and tuberculosis hospitals must continue to obtain, in accordance with existing instructions, certification statements as to the need for inpatient admission.)

H280. OUTPATIENT HOSPITAL SERVICES

Physician certification is not required for the following outpatient hospital services furnished on or after January 3, 1968: (a) hospital services and supplies incident to physicians' services rendered to outpatients (see section 240.2), and (b) diagnostic services furnished to outpatients by a hospital or which the hospital arranges to have furnished in other facilities operated by or under the supervision of the hospital or its medical staff (see section 232). (Outpatient hospital diagnostic services will continue to be covered under Part A through March 31, 1968; thereafter, coverage is transferred to Part B. The amendments eliminate the physician certification requirement with respect to both the Part A and Part B coverage of these services.)

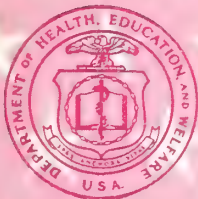
It will still be necessary for hospitals to obtain a physician's certification with respect to services furnished to outpatients that are not covered as outpatient hospital therapeutic or diagnostic services under (a) or (b) above. Primarily, this means that a certification statement is needed for diagnostic services furnished under arrangements by a facility that is not operated by or under the supervision of the hospital or its organized medical staff (see sections 232.2 and 232.3), e.g., services obtained from an independent laboratory. For such services, the existing physician certification instructions on medical and other health services furnished by a provider of services will be followed. Certification by a physician in connection with ambulance services furnished by a participating hospital will continue to be required.

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8-66 CHECK SHEET OF HOSPITAL MANUAL REVISION TRANSMITTALS

This Check Sheet should be placed at the front of the Manual immediately after the Foreword, to provide a record of Manual revisions received. Hospital Manual revisions will be issued under cover of "Revision Transmittals."

<u>Trans.</u> <u>No.</u>	<u>Date</u>	<u>Trans.</u> <u>No.</u>	<u>Date</u>
1.	<u>9/67</u>	21.	_____
2.	<u>12/67</u>	22.	_____
3.	<u>1/68</u>	23.	_____
4.	<u>2/68</u>	24.	_____
5.	<u>3/68</u>	25.	_____
6.	<u>3/68</u>	26.	_____
7.	<u>4/68</u>	27.	_____
8.	<u>5/68</u>	28.	_____
9.	<u>6/68</u>	29.	_____
10.	<u>6/68</u>	30.	_____
11.	<u>7/68</u>	31.	_____
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13.	_____	33.	_____
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17.	_____	37.	_____
18.	_____	38.	_____
19.	_____	39.	_____
20.	_____	40.	_____

Chapter I

GENERAL INFORMATION ABOUT THE PROGRAM

104. Disclosure of Information.—The prohibition against disclosure of program information extends to the beneficiary's health insurance claim number and the fact of his entitlement to health insurance benefits. Disclosure of information to State welfare agencies may be made under certain conditions.

110.2 Posthospital Extended Care Services.—The day of admission, but not the day of discharge, is counted in computing the 3-day prior hospital stay.

110.3 Posthospital Home Health Services.—The 100 home health visits under Part A must be furnished after the beginning of one spell of illness and before the beginning of the next.

122.2A Beginning of Coverage.—The initial general enrollment period for Part B was extended through September 30, 1966, when there was good cause for failure to enroll timely.

122.3C2 End of Coverage.—A social security railroad retirement beneficiary, who was enrolled as a public assistance recipient and then ceases to be a public assistance recipient, may terminate his medical insurance coverage within 3 months thereafter.

Chapter II

COVERAGE OF HOSPITAL SERVICES

202. Hospital Emergency Services.—The appropriate social security regional office with medical consultation by Public Health Service makes the determination of whether an emergency existed. Notices of emergency admissions and billings by nonparticipating hospitals are submitted to the local social security district office and payment is made by intermediaries designated by the Social Security Administration.

202.1 Definition of Emergency Services.—The determination of emergency services depends upon two findings: (1) The patient's condition; and (2) the availability of facilities. Guidelines on what constitutes "the most accessible hospital" are being developed.

202.2 Termination of Emergency Services.—An emergency no longer exists when it becomes safe from a medical standpoint to move the patient.

202.3 Physician's Supporting Statements.—Details of required documentation are given.

205–205.3 Certification of Parts of Institutions as Hospitals.—The parts of institutions certifiable as participating hospitals are clarified.

206. Christian Science Sanatorium.—Sanatorium services are considered hospital services unless the individual elects extended care services. The counting of sanatorium services as inpatient benefit days is explained.

210. Covered Inpatient Hospital Services.—"Inpatient" is defined.

210.1 Accommodations.

210.1B. A hospital having only private accommodations can be paid only the equivalent of the reasonable cost of semiprivate accommodations unless the private accommodations were medically necessary. Where a patient is placed in a private room because less expensive accommodations are not available, the hospital can be reimbursed only for the reasonable cost of semiprivate accommodations. The hospital may not charge the patient for the difference unless the patient requested private accommodations with the knowledge that he would be charged the difference.

210.1C. Where a patient has been placed in accommodations less expensive than semiprivate neither at his request nor for a reason consistent with the program's purpose, payment cannot be in excess of the reasonable cost of ward accommodations. A hospital which repeatedly assigns patients to ward accommodations under such circumstances is subject to termination of its participation agreement.

210.1D. "Most prevalent rate" is defined.

210.2 Nursing and Other Services.—The cost of services of a nonphysician anesthetist is covered. Private duty nurse or attendant is defined.

210.3–210.4 Drugs and Biologicals and Supplies, Appliances and Equipment.—The material on coverage of drugs, supplies, and appliances has been considerably expanded.

210.5 Other Diagnostic or Therapeutic Items or Services.—The services of psychologists and physical therapists to inpatients are reimbursable hospital costs.

"Independent laboratory" is defined. Reasonable charges by such a laboratory for services furnished under arrangements with a hospital represent the hospital's cost for the services. The same rule applies to charges by the laboratory of another participating hospital. Independent laboratories providing services for inpatients under arrangements made by the hospital must meet all of the requirements in the law.

210.7 Inpatient Services in Connection with Dental Services.—The coverage of inpatient services in connection with dental services is explained.

215. Spell of Illness Defined.—The spell of illness begins with transfer to a qualified hospital where a patient was in a nonqualified hospital on his first day of entitlement. Admission to a qualified extended care facility will begin a spell of illness even though the services may not be paid for by the program. In determining the 60-day period for ending a spell of illness, counting begins with the day of last discharge.

216–216.4 Inpatient Hospital Benefit Days.—Inpatient benefit day is defined (§ 216.1) and rules are given for treating late discharge (§ 216.2), leaves of absence (§ 216.3), and the special situations where a patient is discharged on his first day of entitlement or on the first day the hospital participates in the program (§ 216.4).

217–217.3 Inpatient Tuberculosis and Psychiatric Restriction.—The inpatient psychiatric and tuberculosis restriction, when applicable, affects all inpatient hospital benefit days in the initial spell of illness, including those in a general hospital. Rules are provided for determining the patient's status on his first day of entitlement (§ 217.1), the effect of the institution's status in figuring the number of days to be deducted (§ 217.2), and how days of admission, discharge, and leave are treated in figuring the days deducted (§ 217.3). Days of discharge are *not* counted.

219. Inpatient Service Days Counting toward Maximums.—Inpatient days count toward the maximum even though payment cannot be made because of the inpatient deductible or coinsurance provisions.

220. Deductible.—The deductible is satisfied only by charges for covered services, and on an incurred rather than paid basis. Inpatient deductible expenses must have been incurred in the given spell of illness and expenses incurred in meeting the whole blood deductible do not count toward the inpatient deductible. The effect on deductible status and reimbursement when the customary charges are less than the deductible is explained.

222. Whole Blood Deductible.—The rules on the amount the program will pay and the amount the patient may be charged for whole blood have been amplified and clarified. Special rules are included for blood obtained by the hospital from an independent blood bank.

225. Coinsurance.—When the charge for a coinsurance day is less than \$10, the coinsurance rate is the actual charge. The example of the effect of the tuberculosis-psychiatric restriction has been revised to avoid the impression that days of hospitalization in the 90-day preentitlement period must be consecutive, and to reflect the changed position that days of discharge are not counted.

230–240.4 Outpatient Hospital Services.—The material concerning outpatient hospital services under both Part A and Part B has been amplified and completely reorganized. Much of this

material was previously issued in the flyer, "Outpatient Hospital Services Under Medicare." The reorganization makes the basic distinction between identifiable diagnostic tests provided for outpatients covered under Part A and other outpatient hospital services which aid the physician.

Specific items of interest in individual sections are noted in the following:

230. Outpatient Hospital Services—General.—"Outpatient" is defined.

230.1 Rules for Distinguishing Outpatient Hospital Services.—The rules for distinguishing outpatient diagnostic services and other outpatient services are set forth.

232.1 Types of "Arrangements."—Explains the arrangements hospitals currently maintain with other facilities for obtaining laboratory services.

232.2 and 232.3 Diagnostic Services Obtained from Laboratories.—Clarify the coverage under Part B of laboratory services obtained for hospital outpatients under arrangements with an independent laboratory or another participating hospital. In these cases the charges for the services become the cost to the hospital obtaining the services.

234. Other Outpatient Hospital Services Which Aid the Physician.—Defines and exemplifies other outpatient hospital services which aid the physician.

240. Coverage of Hospital Services Under Supplementary Medical Insurance—General.—Part B hospital services and supplies are not covered when furnished to inpatients even when the inpatient is not entitled to Part A benefits, e.g., and individual who remains an inpatient after exhausting his 90 days of inpatient services in a spell of illness.

240.1 Services of Interns and Residents.—Defines the situations in which the services of interns and residents are covered as Part B hospital costs.

240.2 Hospital Services and Supplies Incident to Physicians' Services.—Clarifies the meaning of services and supplies incident to physicians' services. The services of nonphysician anesthetists and psychologists are included as services incident to physicians' services. The required physician supervision of paramedical personnel is explained. Oxygen, and splints, casts, and other devices used for the reduction of fractures and dislocations have been included as examples of supplies incident to physicians' services.

Prosthetic devices and leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes are now included as items which are covered only when furnished incident to a physician's services. Dialysis equipment is given as an example of a prosthetic device replacing an internal body organ. The coverage of prosthetic lenses has been clarified. A definition of "brace" has been included. A terminal device such as a hand or hook is covered when an artificial arm is required by the patient. The cost of an artificial limb or appliance when furnished initially or as a replacement is covered when supplied on the order of a physician.

240.3 Use of Durable Medical Equipment.—The title and contents of this section have been changed to avoid the impression that a hospital can be paid rental for durable medical equipment. A beneficiary cannot be reimbursed for the purchase of such equipment. Oxygen used with hospital-furnished equipment in the patient's home is covered.

240.4 Ambulance Service.—Defines "locality" and otherwise clarifies the requirements for coverage of ambulance services. While transportation to a hospital to obtain home health services is not covered as a home health service, it may be covered under Part B if the specified conditions for coverage are met.

245. Incurred Expenses.—Specifies that the Part B psychiatric services limitation *does not apply to provider services*.

246. Deductible.—Bills count toward the deductible on the basis of incurred expenses; non-covered expenses and expenses incurred prior to entitlement to Part B do not count toward the deductible.

255. Hospital-Based Physicians' Services.—Defines the areas of responsibility of the Part A intermediary and Part B carrier in billing and reimbursement for the services of hospital-based physicians. The provider component of such physician services includes services in connection with autopsies.

260. General Exclusions.

260.1 Not Reasonable and Necessary.—Examples of potential comfort items are included.

260.2 No Legal Obligation to Pay.—The legal obligation to pay requirement has been clarified. The effect of various patient arrangements with homes for the aged on the application of this exclusion is explained.

260.3 Paid for by a Governmental Entity.—Covered services, even if provided free of charge, have been excepted from this exclusion when furnished by a participating State or local government-operated hospital, or a State-operated Veterans' Home and Hospital; or paid for by a State or local governmental entity for certain specified purposes. Effects on coverage of services to prisoners and services paid for by NIH grants.

260.9 Custodial Care.—Custodial care is defined.

260.11 Charges Imposed by Immediate Relatives of the Patient or Members of His Household.—“Immediate relative” and “members of the patient's household” are defined.

260.12 Dental Care.—Clarifies the various procedures which are subject to the dental services exclusion.

270.2 Request for Payment on Hospital Record.—Gives the details of the alternate signature procedure in which the hospital may arrange with its Part A intermediary to have the patient's signature on its admission records serve as the request for payment.

271. Execution of the Request for Payment.—When specimens are submitted for analysis, but the patient himself does not go to the hospital, the hospital may sign the outpatient billing form on the patient's behalf.

273.1 Failure to Obtain Certification and Recertification Statements.—Explains the effect of a physician's refusal to certify or recertify medical necessity.

274. Inpatient Hospital Services Certification.—Explains when a dentist may certify as a “physician” for hospitalization required for dental procedures.

275. Recertification for Inpatient Hospital Services.—Recertification criteria are related to the utilization review guidelines on availability of other facilities in § 290.3.

285. Refunds.—Defines money incorrectly collected.

285.1 Return or Other Disposition of Money Incorrectly Collected.—Describes the manner and time limit for refunding or setting aside money incorrectly collected.

286. Guarantee of Payment Provisions.—The guarantee of payment provision applies only to exhaustion of inpatient benefit days. The coinsurance provision does not apply to days beyond the maximum which are covered by the guarantee of payment.

286.1 Requirements for Payment Under the Guarantee.—“Good faith” and “acted reasonably” have been more precisely defined as conditions under the guarantee of payment. If the hospital retains payments made by the patient for the guarantee period, it should not bill the program for the amounts retained.

289. Workmen's Compensation.—Workmen's compensation plan is defined. The hospital should advise the patient to file for workmen's compensation where a work-related injury or illness is indicated.

289.1 Effect of Workmen's Compensation Payments on Eligibility and Spell of Illness.—Workmen's compensation coverage does not reduce the 190-day lifetime limit on inpatient psychiatric services.

289.2 General Procedures in Workmen's Compensation Cases.—The intermediary will make the determination as to reasonable expectation of payment under workmen's compensation, including lump sum settlement cases, and will notify the hospital of the effect on health insurance benefits.

289.3 Overpayments.—If workmen's compensation results in a health insurance overpayment, the hospital may make direct refund or have the amount of future payments due it adjusted.

290. Utilization Review Plan.—A hospital's utilization review committee may review an inpatient admission at any time. The decision of the committee of one hospital is not binding on the

committee of another hospital. Payments to physicians for services ~~on the utilization review committee~~ are an allowable hospital cost only if the hospital's utilization review plan is applicable to all of the hospital's inpatients.

290.2 Further Inpatient Stay Not Medically Necessary.—The attending physician may give the notice to his patient of the utilization review committee's decision that further inpatient stay is no longer necessary.

290.3 Availability and Appropriateness of Other Facilities and Services.—Gives guidelines for general hospital utilization review committees in determining necessity for continued hospitalization.

Chapter III

ADMISSION PROCEDURES

302.1 Certificate of Social Insurance Award or Temporary Eligibility Notice.—Describes other entitlement notices sent to beneficiaries who have not yet received their health insurance cards.

306.2 The SSA District Office Reply.—Specifies the types of response from the district office when the claim number is not available.

308. Condition is Critical or Discharge is Near.—The procedure for obtaining a health insurance application has been expanded to include cases in which the claim number is unavailable and the patient is near discharge, as well as those in which the patient's condition is critical. Additional information is included on when an application under the procedure becomes effective.

309. Intermediary Requests to Verify Patient's Health Insurance Claim Number.—Discusses hospital handling of intermediary requests to verify health insurance claim numbers when the claim numbers on notices of admission do not match the central record.

310.1 Completing Inpatient Hospital Notice of Admission, Form SSA-1453.—Includes the following substantive changes:

Item 4.—An admission notice can be transmitted where date of birth is unknown.

Item 9.—The address of the attending physician needs to be shown only where the intermediary requires it.

Item 12.—Adds information on identifying a welfare agency when charges are payable under a federally supported assistance program.

Item 13.—Adds the alternate procedure for obtaining the patient's signature on the hospital's admission records.

325. Initiating Notices of Admission Where No Payment Will Be Made.—Several other no-payment situations in which admission notices will be initiated have been included in addition to benefits exhausted cases.

330. Notices of Admission for Emergency Services in Nonparticipating Hospitals.—A new section summarizing admission and billing procedures for nonparticipating hospitals rendering emergency services.

CHAPTER IV

BILLING PROCEDURES

400. Billing Procedures—General.—Explains billing for leaves of absence and repeated discharges and admissions. Former Section 400.1, List of Authorized Signatories, has been eliminated. It will no longer be necessary for hospitals to submit the listings to their intermediaries.

402. Inpatient Hospital Admission and Billing (Form SSA-1453).—Asks for submission of bills for additional types of hospital stays for which no payment can be made but which can begin or extend a spell of illness.

402.1 Completion of Billing Items on the Form SSA-1453.

Item 17. Statement of Services.—Where charges not listed on the form are applied to one of the departments listed, all bills submitted should apply the same charges consistently to the same departments. Describes in greater detail the procedure for submitting the hospital's own billing form in lieu of the detailed completion of Statement of Services. Includes instructions for showing discounted charges.

Explains that noncovered charges should be shown in the Noncovered Charges column except where the noncovered charge is billed routinely to medicare and nonmedicare patients alike, e.g., pathologists' services included in all billings of laboratory charges. Noncovered charges cannot be applied to the deductible, even where noncovered charges are routinely billed to all patients and included in the Total Charges column.

Items A–E. Accommodations.—Accommodation days are always shown as whole rather than fractional days; gives the rules for showing late discharge charges on the billing form. Instructions are included for handling ancillary charges for day of discharge or death and where the patient is discharged on the first day of entitlement. Where there was more than one rate for a given type of accommodation, one of the unused accommodation lines may be relettered and used to show the entry.

Item 17A. One bed.—If the patient was in a one-bed accommodation for other than medical reasons, program payment cannot be made for more than semiprivate accommodations, and the patient may not be charged the difference unless he requested such accommodation. The entries to be made in the Total and Noncovered Charges columns are described.

Items 17D and E. Intensive care and self-care.—Explains billing entries where the patient is in the intensive care unit for part of a day.

Item F. Whole blood.—The explanation for the entries for Pints Furnished, Not Replaced, Charge per Pint, and Total and Noncovered Charges has been revised and expanded to take account of the expanded statement in § 222, particularly as regards blood obtained from independent blood banks.

G–O. General.—Explains how items and services which are more expensive or in excess of the services covered by the program, should be shown in the Total Charges and Noncovered Charges columns. Where the patient did not request such services, only the covered charges should be shown in the Total Charges column, and no entry made in the Noncovered Charges column. Where the patient requested such services and the hospital will bill him for them, the Total Charges column will reflect the full charge and the Noncovered Charges column will show the excess charge billed to the patient.

P. Inpatient deductible.—This line should show total charges in line "O" minus any physician's charges included in total charges.

R. Coinsurance.—In addition to the total deduction for coinsurance, the rate and the number of days should be shown. The coinsurance rate is \$10 or the daily charge, whichever is less.

Item 18. Statement Covers Period.—This item should show inclusive dates whether or not all days are covered, except that days before the patient's entitlement will not be shown. An example shows how this item is completed where the hospital bills periodically for a continuous stay.

Item 19. Total Days.—Explains what days should not be included in this item, i.e., benefits exhausted and guarantee of payment does not apply; workmen's compensation payment is made or can be expected to be made; a National Institutes of Health grant will pay; services are not covered; days on which the patient was on a leave of absence or is away from the hospital because of repeated admissions and discharges; the day of discharge or death. An explanation of noncovered days is required in the Computation of Interim Payment block.

Indicates entries to be made where an individual is admitted as an inpatient and is discharged or transferred to another hospital before midnight of the day of admission.

Item 21. Date Benefits Exhausted.—This item should not be completed unless benefits are exhausted before date of discharge or death, and during period covered by Item 18. A projected date should not be used.

Item 26. Hospital Certification and Signature Lines.—The date forwarded should be the date the bill is actually forwarded to the intermediary. The date used should not be before the “To” date in the “Statement Covers Period” item. A stamped signature is acceptable for the SSA-1453 as well as all other hospital billing forms.

All-Inclusive Rate Hospitals.—Provides billing guides for hospitals using all-inclusive rates.

410-410.2 Inpatient Psychiatric or Tuberculosis Admission and Billing (Form SSA-1485).—Revised to reflect changes made in Sections 400, 402, 402.1, and 402.2.

412-412.1 Explanation of Accommodation Furnished (Form SSA-1484).—The instruction on when the SSA-1484 is to be completed reflects the position on payment for accommodations in hospitals having only private rooms as indicated in § 210.1.

Item 6. Type of Accommodation Furnished.—Explains how to compute the most prevalent semiprivate rate.

Item 7. Reason for Assignment to Accommodation Mentioned. Eliminates from Item C, Other Reasons, an explanation for a one-bed assignment where it was not medically necessary, since program payment may not be made in such a situation.

420. Outpatient Hospital Billing (Form SSA-1483).—Explains when fully completed bills should be submitted although the hospital will not receive program reimbursement. Additional guidelines are also given for the billing of one complete diagnostic study.

420.1 Completing Items on Form SSA-1483.—Has a number of revisions on the completion of items.

Item 5. Date of Birth.—The date of birth should be shown if available. However, if it is not available, the billing form may be submitted without it.

Item 9. Name and Address of Physician Requesting Outpatient Services.—The physician’s address need not be shown unless the intermediary requires it.

Item 10. Payment Source.—If the hospital will not bill anyone for expenses not reimbursable under the program, this item need not be completed. The identifying information required if a public agency is involved will assist the intermediary in forwarding a copy of the bill to that agency, when appropriate.

Item 11. This date should be the first date the patient was seen for a diagnostic study.

Item 12. Patient’s Certification and Payment Request.—Incorporates the procedure on obtaining the patient’s signature on the hospital’s record and signature by the hospital when the patient does not visit the hospital, from §§ 270-271.

Item 14. Statement of Services.—Provides categories to be used where possible for reporting laboratory tests. Only one bill should be completed even though services were rendered by different outpatient departments. Where necessary, more than one form may be used to report the services in the same billing; the items to be completed on the additional forms are indicated.

430. Provider Billing for Patient Services by Physician (Form SSA-1554).—Explains when the SSA-1554 form will be submitted directly to the Part B intermediary, e.g., covered hospital days in a spell of illness are exhausted, or the patient receives physician services in the hospital after the utilization review committee has determined further hospitalization is not necessary. The SSA-1554 must be completed in every case where the provider takes assignment on reimbursable amounts even though the charges for physician services do not exceed the deductible amount collected. This will insure that all Part B expenses are recorded to the beneficiary’s account.

430.1 Completing Items on Form SSA-1554.—The instructions for completion of item 10 of the SSA-1554 have been changed as follows for the “optional” method:

10A. Date of Service.—Inclusive dates may be used with “optional” method.

10B. Name of Physician.—May be omitted when the “optional” method is used.

10D. Surgical or Medical Procedures.—May be omitted when the “optional” method is used and department is identified in 10E.

10F and 10G. **Total Charge and Percentage of Total Charge.**—Under the “optional” method, the total provider charge is shown in 10F and the uniform approved departmental percentage for physician’s component is shown in 10G.

430.3 Description of “Item-by-Item” and “Optional” Methods for Physicians’ Components. Defines the terms “item-by-item” and “optional” method as used in § 430.1.

450. Procedure for Submitting Inpatient Billing After Exhaustion of Benefits or When No Payments Are Due. Describes additional situations where no payment can be made, but which nevertheless call for the submission of a billing form.

460. Procedure for Submitting Corrected Bills. Requires only submission of the corrected copy of the bill. The intermediary will prepare any additional copies which are required. A tolerance rule on submission of corrected bills is given.

Health Insurance for the Aged

HOSPITAL MANUAL

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USING THE HOSPITAL MANUAL

Use It for Reference

The manual covers not only routine information for your day-to-day operations but tries to anticipate infrequent situations that could occur. It has been indexed for ease of reference.

Keep It Available

Pages are punched for any standard-size three-ring binder. Keep it handy and ask for as many extra copies as you need.

Keep It Up-to-Date

Insert or replacement pages for additions and revisions will be furnished through your intermediary. Maintain a control on all manuals to assure immediate updating.

FOREWORD

This manual is designed for use by hospitals which will be billing for services furnished under the provisions of the Health Insurance for the Aged Act of 1965. It contains informational and procedural material the hospital will need to assist in prompt and efficient payment of claims and to answer questions which patients may ask about the program. This issuance should help to assure that the law is uniformly applied nationally without regard to where covered services are furnished. The hospital's intermediary will issue any necessary additional instructions on matters which concern the relationship between hospitals and intermediaries.

The manual does not have the effect of regulations, but a careful effort has been made to insure that the provisions of the law, the regulations and proposed regulations are accurately reflected.

The procedures described in this manual have been devised to satisfy the administrative needs of the program with a minimum of inconvenience to beneficiaries, and to hospitals and their intermediaries. We believe that the vast majority of claims will lend themselves to simple, routine handling.

The manual is designed to accommodate new pages as further interpretations of the law and changes in procedures are made. Accordingly, revised sections, pages, or chapters will be issued as the need presents itself.

Your intermediary will answer any questions you may have about policies and procedures in the program. Hospitals dealing directly with the Social Security Administration may direct questions to the servicing social security district office for reply or refer them to the Bureau of Health Insurance Regional Representative.

THOMAS M. TIERNEY
Director, Bureau of Health Insurance

Chapter I

GENERAL INFORMATION ABOUT THE PROGRAM

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CHAPTER I
1967 AMENDMENTS SUPPLEMENT

GENERAL INFORMATION ABOUT THE PROGRAM

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Chapter I

GENERAL INFORMATION ABOUT THE PROGRAM

100. INTRODUCTION

The Health Insurance for the Aged Act, Title XVIII of the Social Security Act, known as "Medicare," has made available to nearly every American 65 years of age and older a broad program of health insurance designed to assist the Nation's elderly to meet hospital, medical, and other health costs. The program includes two related health insurance programs—hospital insurance (Part A of the law) and voluntary supplementary medical insurance (Part B of the law).

The conduct of the program has been delegated by the Secretary of Health, Education, and Welfare to the Commissioner of Social Security. Congress has provided substantial administrative roles for the States and for voluntary insurance organizations in recognition of their experience in the health care and insurance fields.

The law specifically prohibits the Federal Government from exercising supervision or control over the practice of medicine, the manner in which medical services are provided, and the administration or operation of medical facilities. The patient is free to choose any qualified institution, agency, or person offering him services. The responsibility for his treatment and the control of his care remains with his physician and the hospital or other facility or agency furnishing him services. The individual may keep or obtain any other health insurance available, if he desires.

102. DISCRIMINATION PROHIBITED

Participating providers of services under the hospital insurance program, i.e., hospitals, extended care facilities, and home health agencies, must comply with the requirements of Title VI of the Civil Rights Act of 1964. Under the provisions of that Act a participating hospital is prohibited from making a distinction on the ground of race, color, or national origin in the admission and treatment of patients; the accommodations provided; the use of equipment and other facilities; and the assignment of personnel to provide services.

Title VI prohibits discrimination on the ground of race, color, or national origin in the selection by the

hospital of physicians, surgeons, dentists, or other practitioners seeking the privilege of practicing in the hospital, as well as of consultants, advisers, volunteers, and observers.

The Department of Health, Education, and Welfare is responsible for investigating complaints of non-compliance.

104. DISCLOSURE OF HEALTH INSURANCE INFORMATION

Records and information acquired in the administration of the Social Security Act are confidential and may be disclosed only under the conditions prescribed in rules and regulations or on the express authorization of the Commissioner of Social Security. The regulations of the Department of Health, Education, and Welfare regarding the confidentiality of records and information apply to governmental and private agencies participating in the administration of the program; to institutions, facilities, agencies, and persons providing services; and to those furnishing services under arrangements with a provider of services.

Information furnished specifically for purposes of a claim under the health insurance program is subject to these rules and regulations. Such information includes the individual's health insurance claim number, the fact of his entitlement to health insurance benefits, and medical and other information obtained from the Social Security Administration or an intermediary.

However, the information in the provider's own medical records of a patient is not subject to these rules and regulations even though the patient receives benefits under the health insurance program. These records are subject to the requirement of confidentiality in the "Conditions of Participation for Hospitals," and may also be subject to State or local laws or hospital rules governing disclosure.

A provider may disclose records or information acquired under the health insurance program only when the record or information is to be used in connection with a claim for health insurance benefits; and the disclosure is necessary for the proper performance of the duties of any officer or employee of (1) the Depart-

ment of Health, Education, and Welfare, or (2) any public or private agency or organization under an agreement with the Secretary of Health, Education, and Welfare.

A State agency certifying providers in the health insurance program may disclose to the State licensing authority information furnished by a hospital relating to the hospital's compliance or noncompliance with the licensure requirements. Prior approval by the Department of Health, Education, and Welfare is a condition for such disclosure.

The Social Security Administration has issued guidelines for intermediaries in arranging to supply billing information to State public welfare agencies when payment of the cost of hospitalization is to be made under both the health insurance and State welfare programs. State public welfare agencies which have entered into agreements with health insurance intermediaries will make any necessary arrangements with the hospitals involved.

110. HOSPITAL INSURANCE (PART A)

This is the basic part of the health insurance program. It is designed to help patients defray the expenses incurred by hospitalization and related care. In addition to inpatient hospital benefits, hospital insurance covers outpatient hospital diagnostic services, and posthospital care in extended care facilities. It also covers posthospital care furnished by a home health agency in the patient's home. In providing these additional benefits, recognition was given to the need for continued treatment after hospitalization and the need to encourage the use of less expensive substitutes for inpatient hospital care. Program payment for services rendered to beneficiaries by providers (i.e., hospitals, extended care facilities, and home health agencies) may be made only to the provider, and is based on the reasonable cost of the covered services furnished.

110.1 Hospital Services Covered Under Hospital Insurance.—Hospital services covered under hospital insurance include inpatient hospital services and outpatient hospital diagnostic services. These benefits and the applicable deductibles, coinsurance, limitations, and exclusions are fully treated in chapter II of this manual. What follows in this section is a brief description of the other covered services under hospital insurance.

110.2 Posthospital Extended Care Services.—In each spell of illness (as defined in chapter II) payment may be made for the reasonable cost of up to 100 days of posthospital extended care services, except that the patient is responsible for \$5 per day after the 20th

day. The beneficiary must have been a hospital inpatient for at least 3 consecutive days (counting the day of admission but not the day of discharge) and be admitted to the extended care facility within 14 days after the date of hospital discharge. (Benefits for posthospital extended care are payable for services furnished on or after January 1, 1967. The hospital discharge must have occurred after June 30, 1966, or on or after the first day of the month in which the beneficiary attains age 65, whichever is later.)

An extended care facility provides skilled nursing care and related services for patients who require medical or nursing care; or rehabilitation services for injured, disabled, or sick persons. It may be either a separate institution (e.g., a nursing home) or a part of an institution (e.g., a convalescent wing of a hospital). It must be licensed or approved under State or local law, meet the health and safety conditions prescribed by the Secretary of Health, Education, and Welfare, and have a written transfer agreement with one or more participating hospitals providing for the transfer of patients between the hospital and the facility, and for the interchange of medical and other information. If an otherwise qualified extended care facility has attempted in good faith but without success to enter into a transfer agreement, this requirement may be waived by the State agency described in § 132.

A facility which is primarily for the care and treatment of mental disease or tuberculosis is excluded from the definition of extended care facility.

Extended care services include room and board; skilled nursing care by or under the supervision of a registered nurse; physical, occupational, or speech therapy; medical social services; and other services ordinarily furnished by the facility. No payment may be made for custodial care or for items or services which would not be covered in a hospital.

The services of residents and interns of a hospital with which the facility has a transfer agreement and other diagnostic and therapeutic services furnished by such a hospital are covered, but only if billed through the extended care facility.

110.3 Posthospital Home Health Services.—Home health services under hospital insurance include up to 100 home health visits, after the beginning of one spell of illness and before the beginning of the next, furnished a patient within 1 year of his most recent discharge from a hospital of which he was an inpatient for at least 3 consecutive calendar days. If, after his hospitalization, he had a covered stay in an extended care facility, the 1 year during which the patient may

receive home health services begins with the discharge from the extended care facility. A plan of treatment must be established within 14 days after the hospital or extended care facility discharge. Home health services are provided also under supplementary medical insurance. (For the latter see § 115.)

The patient receiving posthospital home health services must be confined to his home and under the care of a physician who establishes and periodically reviews the plan for his patient's care. To be covered the services must be required by a condition for which the patient required inpatient hospital services or extended care services. Discharge from the required period of hospitalization must have occurred after June 30, 1966, or on or after the first day of the month in which the patient attains age 65, whichever is later.

Home health services are services provided by a home health agency or by others under arrangements with such an agency. A home health agency is a public agency or private organization which is primarily engaged in providing skilled nursing and other therapeutic services. Where applicable, the agency must be licensed under State or local law, or be approved by the State or local licensing agency as meeting the licensing standards. Examples of home health agencies are visiting nurse associations, official health agencies, and hospital-based home care programs.

To participate in the health insurance program a home health agency must meet certain other requirements included in the law as well as health and safety conditions prescribed by the Secretary of Health, Education, and Welfare. It may **not** qualify under **hospital** insurance, however, if it is primarily engaged in the treatment of mental diseases.

These services are usually furnished on a visiting basis in a place of residence used as the individual's home. However, outpatient services in a hospital, extended care facility, or rehabilitation center are covered home health services, if arranged for by a home health agency, when equipment is required that cannot be made available in the patient's home.

Covered home health services include part-time nursing care by or under the supervision of a registered professional nurse; physical, occupational, or speech therapy; medical social services; certain services of a home health aide; medical supplies (other than drugs and biologicals); and the use of medical appliances. The cost of housekeepers, food service arrangements, and transportation to outpatient facilities is excluded as home health services.

The services of an intern or resident are covered if the agency and hospital are affiliated or under common control and the agency bills for the services.

115. SUPPLEMENTARY MEDICAL INSURANCE (PART B)

The voluntary medical insurance plan is designed to supplement the basic hospital insurance coverage. It provides coverage for the expense of physicians' services, including surgery, consultation, and home, office, and institutional calls. (Physician services do not include the services provided by an intern or resident.)

Medical insurance covers home health services for up to 100 visits during the calendar year (in addition to the visits covered under hospital insurance) but without the requirement of prior inpatient care.

The plan provides coverage for services and supplies (including drugs and biologicals which cannot be self-administered) furnished incident to a physician's professional service of a type usually furnished in a physician's office and usually rendered without charge or included in the physician's bill.

See §§ 230-234 and 240 ff., "Hospital Services Under Supplementary Medical Insurance" for a fuller discussion, including additional items and services included in this part of the program for which hospitals may be reimbursed, and for the medical insurance deductible and coinsurance.

The amount of payment for covered services rendered by other than providers under the medical insurance plan is determined by the designated medical insurance intermediary on a **reasonable charge** basis. Payment is made to the beneficiary unless the physician or other supplier of services has accepted an assignment, in which case payment is made to the physician or supplier. In determining the reasonableness of charges, Part B carriers take into consideration the customary charges of the physician (or other person rendering the service) as well as the prevailing charges which are generally made in the locality for similar services. A charge is **not** reasonable if it is higher than the charge applicable for a comparable service and under comparable circumstances to the intermediary's own policyholders or subscribers.

Reimbursement to a provider for services covered by the medical insurance plan is made by the provider's (Part A) fiscal intermediary on a reasonable cost basis. In cases where the provider has elected to deal directly with the Government, the provider will be re-

imbursed by the Social Security Administration for services covered by medical insurance.

Payment for the services of hospital-based physicians (other than interns and residents) rendered to individual beneficiaries is made by the medical insurance (Part B) carrier designated to make payment for physicians' services.

120. ENTITLEMENT TO HOSPITAL INSURANCE

A. An individual is **automatically** entitled to hospital insurance beginning with the first day of the month he attains age 65 if he has **applied for** and been determined to be entitled to monthly social security benefits (although he may not actually be receiving benefit payments; e.g., he has not retired). Automatic entitlement also extends to qualified beneficiaries under the Railroad Retirement Act. (For social security purposes, a person attains age 65 on the day before his 65th birthday. Example: If birth date is August 1, attainment date is July 31, and health insurance entitlement date is July 1.)

An individual entitled to hospital insurance may also be enrolled in a health plan administered by the Civil Service Commission. In such a case the provider bills medicare. The beneficiary should contact the Federal health benefits carrier for complementary benefits.

A social security applicant who applies for monthly benefits after the month he reaches age 65 is entitled to retroactive hospital insurance benefits beginning with the first month in which he had attained age 65 and met all the requirements for monthly benefits, but not for more than 12 months before the month in which he filed his application.

Entitlement to hospital insurance benefits ends with the month the individual ceases to be entitled to social security monthly benefits or ceases to be a qualified railroad beneficiary (for example, a woman whose wife's benefits are terminated by divorce). A person who ceases to be a social security or railroad retirement beneficiary but who meets the requirements of the special transitional provision described below may reinstate his hospital insurance by filing a proper application under the transitional provision.

Hospital insurance coverage continues for the month of death, although no monthly cash benefits are payable for the month of death.

B. A special **transitional** provision in the law permits persons 65 years of age and over, who cannot qualify for monthly social security or railroad retirement benefits, to obtain hospital insurance upon filing

application. Such an individual must be a resident of the United States and either a citizen or an alien lawfully admitted for permanent residence who has resided in the United States continuously for 5 years. He may not be an active or retired Federal employee (or spouse of one) who is or could have been covered by the Federal Employees Health Benefit Act of 1959. He may not have been convicted of a crime against the security of the United States.

For coverage under the transitional provision, a person attaining age 65 after 1967 must have three quarters of coverage for each year elapsing between 1965 and the year in which he attains age 65.

Hospital insurance under the transitional provision can also be retroactive for as many as 12 months before the month of application, provided the individual meets all the other requirements during the period of retroactivity.

122. ENTITLEMENT TO SUPPLEMENTARY MEDICAL INSURANCE

A. **Enrollment.**—To obtain supplementary medical insurance coverage an individual must voluntarily enroll in the plan and pay the required premiums. He may enroll if he is entitled to hospital insurance benefits or, if he is age 65, a resident of the United States, and either a citizen or an alien admitted for permanent residence. Active or retired Federal employees and their spouses are eligible to enroll whether or not covered under the Federal Employees Health Benefit Act. (For social security purposes an individual attains age 65 on the day before his 65th birthday.)

By agreement States may enroll in the supplementary medical insurance plan eligible individuals who are receiving money payments under certain public assistance programs. Such persons who are entitled to monthly social security or railroad retirement benefits may be included at the option of the State.

B. **Enrollment Periods.**—Enrollment is possible only during specified enrollment periods.

1. During the **initial general enrollment period** an opportunity to enroll was afforded to all eligible persons age 65 and over before March 1, 1966. This enrollment period ended May 31, 1966. (An eligible individual who for good cause failed to enroll before June 1, 1966, could have enrolled before October 1, 1966.)

2. For persons first eligible on or after March 1, 1966, the **initial enrollment period** is 7 months. It begins 3 calendar months before and ends 3 calendar months after the month in which the individual first meets all enrollment requirements.

3. **General enrollment periods** occur October 1 through December 31 of each odd-numbered year beginning with 1967. Those who failed to enroll during their initial enrollment periods and those whose enrollment has terminated may enroll in these periods.

4. **States which desire to enroll eligible individuals receiving public assistance** must request coverage before January 1968, and enter into an agreement with the Government.

An individual who fails to enroll for medical insurance within the 3-year period after the close of his initial enrollment period may not enroll thereafter.

An individual whose enrollment has terminated may re-enroll only once—in a general enrollment period which begins within 3 years after the termination of his prior enrollment.

Payment may be made for covered services if the individual was enrolled at the time the services were furnished, even though at the time the request for payment is filed with the intermediary his enrollment had been terminated.

122.1 Premiums.—Initially, the premium is \$3 per month. The law permits the Secretary of Health, Education, and Welfare to adjust the premium amount in accordance with changes in medical and other costs. No change in the premium is permitted before 1968, and changes thereafter can be no oftener than every 2 years. To take into account the higher cost of insuring older individuals, premiums payable by a person who enrolls after the first enrollment period open to him, or who re-enrolls after his initial enrollment was terminated, are increased by 10 percent for each year he could have been but was not enrolled.

A grace period has been provided for payment of premiums. This period extends for 2 calendar months after the month in which the premium is due.

Persons enrolled for medical insurance and receiving social security, railroad retirement, or civil service retirement benefits (except those enrolled by the State as public assistance recipients) will have the premiums withheld from their monthly checks. The State pays the premiums for the public assistance recipients it enrolls.

Other enrollees must make premium payments directly to the Social Security Administration. Enrollees who make direct premium payment will generally be billed quarterly. However, organizations, employers, unions, etc., may under certain conditions pay premiums for their members as a group.

122.2 Beginning of Coverage

A. Enrollment during the initial general enrollment period—coverage began July 1, 1966. An individual who attained age 65 prior to March 1966, and who, on establishing good cause for failure to enroll timely, enrolled from June 1, 1966, through September 30, 1966, has coverage beginning the first day of the sixth month after the month in which he enrolled.

B. Enrollment during an entitled individual's initial enrollment period—coverage begins:

1. First day of the month in which the individual becomes age 65, if he enrolls **before** the month that he becomes 65.

2. First day of the month following the month that he becomes age 65, if he enrolls **in** the month that he becomes 65.

3. First day of the second month after the month of enrollment, if he enrolls in the month **after** he becomes age 65.

4. First day of the third month after the month of enrollment, if he enrolls **more than 1 month after** the month in which he became age 65. (However, individuals who became age 65 in March 1966, and enrolled in May 1966, have coverage effective July 1, 1966.)

C. Enrollment during one of the general enrollment periods—coverage begins the following July 1st.

D. Enrollment by a State of its welfare recipients—coverage begins on the latest of the following but not later than January 1, 1968:

1. July 1, 1966;

2. First day of the third month after the month of the agreement with the State;

3. First day of the first month in which the individual is both eligible and a member of the group;

4. The date specified in the agreement.

122.3 End of Coverage

A. An individual whose medical insurance premiums are being deducted may notify the Social Security Administration in writing during a general enrollment period that he no longer wants medical insurance. His coverage period will be terminated with the close of the year in which his notice is submitted.

B. Enrollment under medical insurance is terminated because of nonpayment of premiums. Termination is effective with the end of the grace period provided for payment of premiums.

C. If an individual is enrolled under a Federal-State agreement, his coverage under the agreement ends on whichever of the following first occurs:

1. The end of the month in which he becomes ineligible (as determined by the State) for welfare money payments; or

2. The end of the month before the first month for which he becomes entitled to monthly social security or railroad retirement benefits, unless the State exercises its option to enroll its welfare recipients who are entitled to such benefits.

If an individual's coverage under a Federal-State enrollment agreement is terminated, his coverage continues without interruption subject to the applicable premium payment requirements.

A social security or railroad retirement beneficiary or civil service annuitant who was enrolled under a State agreement and thereafter ceases to be a public assistance recipient may terminate his enrollment during the 3-month period after the month he leaves the public assistance rolls.

D. If not otherwise terminated, coverage ends with the beneficiary's death.

130. FEDERAL GOVERNMENT ADMINISTRATION OF THE HEALTH INSURANCE PROGRAM

The Department of Health, Education, and Welfare has been given overall responsibility for administration of the hospital insurance and voluntary supplementary medical insurance programs. Three major agencies of the Department—the Social Security Administration, Public Health Service, and Welfare Administration—are involved.

130.1 The Social Security Administration has the responsibility for policy formulation and the general management and operational aspects of the program. Briefly, these include: determination of the individual's entitlement to benefits and the nature and duration of services for which benefits may be paid; establishment, maintenance, and administration of agreements with State agencies, providers of services and intermediaries; in consultation with the Public Health Service and the Welfare Administration, the formulation of major policies regarding conditions of participation for providers; the development and maintenance of statistical research and actuarial programs; and the general financial management of the program. The Administration also makes determinations of reasonable costs and amounts to be paid to providers who have elected to deal directly with the Government.

130.2 The Public Health Service has the principal responsibility for the professional health aspects of the program. These include: professional consulta-

tion and recommendation to the Social Security Administration in development of health and safety, and other guidelines for determining whether providers of services meet the conditions for participation under the program; consultation and advice to State agencies concerning the application of standards for providers, and in the coordination of program activities with other health services and activities in the State; and activities necessary in studying the utilization of hospital and other medical care services under the program.

130.3 The Welfare Administration has the primary role in hospital and medical insurance program planning, coordination, and evaluation in matters that affect other federally aided assistance programs; in assisting State agencies to achieve a coordinated approach with other medical care plans under the Social Security Act; and in all aspects of program administration affecting public welfare agencies.

131. ADVISORY GROUPS

The law provides for the appointment of two non-governmental advisory groups to assist the Secretary.

131.1 The Health Insurance Benefits Advisory Council, consisting of persons outstanding in hospital, medical, and other health activities, and at least one representative of the general public, advises the Secretary on general policy in administering the program and in the formulation of regulations. The Secretary must consult with the Council in determining conditions of participation for hospitals and other providers of services in addition to the requirements specifically enumerated in the law.

131.2 The National Medical Review Committee is to be selected from people who are representative of professional organizations and associations in the field of medicine and other individuals who are outstanding in the field of medicine or in related fields. At least one member will represent the general public and a majority of the committee are to be physicians. The committee studies the utilization of hospital and other medical services under the program and makes any recommendations to the Secretary and to Congress that it considers appropriate.

132. STATE AGENCIES

The States are accorded important administrative functions to the extent that each is willing and able to undertake them by agreement with the Secretary.

A. Certifications are made by State agencies to the Department of Health, Education, and Welfare indicating whether hospitals, extended care facilities,

home health agencies, and independent laboratories meet and continue to meet their respective conditions of participation. This function is intended to be a natural adjunct to ongoing State activities, such as licensing of health facilities and other standard setting activities.

B. Consultation services are rendered by State agencies if their agreements provide for it. Consultation with hospitals, extended care facilities, and home health agencies that need and request assistance to meet the conditions of participation is an integral part of the certification process.

C. Coordination by the State relates its activities in the performance of its functions under the program to the various other programs in the State that have to do with payment for health care, quality of care, and distribution of health facilities. Coordination of such activities is designed to utilize existing State facilities and trained personnel effectively and economically and to prevent duplication of effort.

D. State Agency as a Medical Insurance Intermediary.—Where a State enters into an agreement with the Government to pay the medical insurance premium on behalf of its aged welfare recipients, as explained in § 122A the agreement may provide for a designated State agency to serve as an intermediary on behalf of its welfare recipients.

135. HOSPITAL INSURANCE INTERMEDIARIES

Under the hospital insurance plan, groups or associations of providers, on behalf of their members, may nominate a national, State, or other public or private agency, or organization to serve as intermediary in the claims process. A member of an association is free, however, to receive payment from an approved intermediary other than its association's nominee, if agreeable to the Social Security Administration and to the intermediary selected. A provider may deal directly with the Social Security Administration.

The law permits the Administration to enter into an agreement with a nominated organization if it finds this to be consistent with effective and efficient administration of the hospital insurance program. The intermediary makes payments to providers for covered items and services on the basis of reasonable cost determinations and assists in the application of safeguards against unnecessary utilization of covered services. The agreement may also call for furnishing consultative services to assist providers to establish and maintain necessary fiscal records and otherwise qualify as providers of services; serving as a center for commu-

nicating with providers; and making audits of provider records.

Generally speaking, the Social Security Administration will utilize the services of the hospital insurance intermediary in making payments for hospital and other provider services under medical insurance.

See § 255 for the hospital insurance intermediary's role in making payment determinations for services of hospital-based physicians.

137. MEDICAL INSURANCE CARRIERS

The law requires the Secretary to enter into contracts with carriers selected to serve as intermediaries for the performance of specified administrative functions under the medical insurance program. Carriers are generally assigned to serve a geographical area in which medical services are furnished. However, railroad retirement beneficiaries are served by The Travelers Insurance Company regardless of where services are furnished, and welfare recipients may be served by a State welfare agency. The principal function of this intermediary is to determine whether physicians' (including hospital-based physicians, see §§ 255 and 430) charges are reasonable and to make payment. Section 132D of this chapter explains the conditions under which a State agency may act as a supplementary medical insurance intermediary.

140. FINANCING HOSPITAL INSURANCE PROGRAM

The hospital insurance program is financed through separate payroll contributions paid by employees, employers, and self-employed persons. The proceeds are earmarked for the Federal Hospital Insurance Trust Fund to keep them separate from other social security contributions. The law permits their use only for the payment of hospital insurance benefits and administrative expenses. The cost of providing hospital insurance benefits to persons who are not social security or railroad retirement beneficiaries is met by appropriations to the Federal Hospital Insurance Trust Fund from general revenues.

142. FINANCING SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

The supplementary medical insurance plan is financed by the monthly premiums of those who enroll under the plan, matched by an equal contribution from general revenues. All premiums and Government contributions for this plan are placed in a separate fund known as the Federal Supplementary Medical Insurance Trust Fund. This fund is devoted exclusively to the payment of medical insurance benefits and administrative expenses.

Hospital Insurance Benefits Entitlement

H120 B. Transitional Provision.--The 1967 amendments modify the quarters of coverage requirement of the transitional provision. The person attaining age 65 after 1967, who is not entitled to monthly benefits under social security or railroad retirement, will need three less quarters of coverage than under the pre-amendment provision.

Supplementary Medical Insurance Benefits

H122 A. Enrollment.--The 1967 amendments provide that States will be given the option of "buying-in" for all their aged who are eligible for medical assistance under Title XIX, not just for those receiving cash assistance.

B3 General Enrollment Period.--The first general enrollment period was to occur October 1, 1967, through December 31, 1967. By special Congressional action, however, this period was extended through March 31, 1968. The 1967 amendments provide that effective January 1, 1969, the general enrollment period will be annual rather than biennial and will run from January 1 through March 31 rather than October 1 through December 31. Coverage will begin on the following July 1.

B4 States.--The 1967 amendments extended from January 1968 to January 1970 the deadline before which States may request an agreement with the Secretary to enroll eligible individuals under the "buy-in" provision. States are also permitted to cover under the agreement persons who become eligible for assistance after the agreement date.

H122.1 Premiums.--Through March 1968, the individual supplementary medical insurance premium was \$3. The law permitted the Secretary of Health, Education, and Welfare to adjust the premium amount if costs should rise, and in December 1967, the Secretary announced a new premium rate of \$4 effective April 1968 through June 1969.

With the 1967 amendments, the law specifies that the Secretary will determine and make known during December of each year the premium rate which will be applicable for a 12-month period to begin the following July 1. When the Secretary makes known a rate change for

Part B, he will issue a public statement setting forth the actuarial assumptions and other bases upon which he arrived at the new rate.

HL22.2 Beginning of Coverage

D. Enrollment by a State of its welfare recipients under the 1967 amendments--coverage begins on the latest of the following:

1. July 1, 1966.(no change)
2. First day of the third month after the month of the agreement with the State. (no change)
3. First day of the first month in which the individual is eligible and a member of the group except that (for a State which buys in for medically indigent persons) if the individual is not in such month receiving money payments under titles I, IV(Part A), X, XIV, or XVI, his coverage will begin on the first day of the second month after such month, or on the first day of the first month in which he receives a money payment under one of the above titles, whichever occurs first. (1967 amendments)
4. The date specified in the agreement.

HL22.3A Coverage Ends--Prior to the 1967 amendments, an individual could request termination of medical insurance by notifying the Social Security Administration in writing during a general enrollment period and coverage would terminate at the close of the general enrollment period. Because of the extension of the 1967 general enrollment period to April 1, 1968, coverage might end on either December 31, 1967, or March 31, 1968, the effective termination date being determined by the period during which the termination request was filed.

The 1967 amendments provide that beginning April 1, 1968, an individual wishing to disenroll ~~may~~ do so at any time, but such disenrollment will not take effect until the close of the calendar quarter following the calendar quarter in which the notice of disenrollment is filed.

If an individual is enrolled under a Federal-State agreement, his coverage under the agreement ends on whichever of the following occurs first:

1. The end of the month in which he becomes ineligible (as determined by the State) for both welfare money payments or medical assistance (if the agreement covers individuals eligible for medical assistance under title XIX). (1967 amendments)

2. The end of the month before the first month for which he becomes entitled to monthly social security or railroad retirement benefits (if the State's agreement covers only money recipients who are not entitled to such benefits).

3. The end of the month in which the State agreement is terminated.

4. The end of the month in which the individual dies.

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Chapter II

COVERAGE OF HOSPITAL SERVICES

Definitions

200. HOSPITAL DEFINED

A **Hospital (Other Than Tuberculosis or Psychiatric)** is an institution which:

a. is primarily engaged in providing to inpatients, by or under the supervision of physicians,

(1) diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or

(2) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

b. maintains clinical records on all patients;

c. has bylaws in effect concerning its staff of physicians;

d. requires that every patient must be under the care of a physician;

e. provides 24-hour nursing service by or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;

f. has in effect a hospital utilization review plan;

g. is licensed or is approved by the State or local licensing agency as meeting the standards established for such licensing;

h. meets other health and safety requirements of the Secretary of Health, Education, and Welfare. (These additional requirements may not be higher than comparable ones prescribed for accreditation by the Joint Commission on Accreditation of Hospitals with certain exceptions specified in the law.)

i. is not primarily for the care and treatment of mental diseases or tuberculosis.

201. PARTICIPATING HOSPITAL

Payment may ordinarily be made only to a participating hospital for covered services furnished by the hospital or by others under arrangements with the hospital. A participating hospital is an institution approved by the Social Security Administration which has entered into an agreement with the Administration

not to charge any patient or other person for covered items and services, except deductibles and coinsurance amounts; to return any money incorrectly collected; and to provide services on a nondiscriminatory basis in compliance with Title VI of the Civil Rights Act of 1964.

202. HOSPITAL EMERGENCY SERVICES

A nonparticipating hospital is one which does not have an agreement to participate whether or not it meets the other requirements for participation. Such a hospital, however, may receive payment for inpatient hospital services or outpatient hospital diagnostic services furnished by it, or by others under arrangements with it, if:

a. the services are **emergency services**; and

b. the services are covered services under **hospital insurance**; and

c. the hospital meets the definition of a hospital, psychiatric hospital, or tuberculosis hospital (but it need not meet the utilization review plan and the health and safety conditions prescribed by the Secretary); and

d. the hospital agrees **on an individual case basis** not to charge the patient or other person for items or services covered by hospital insurance except deductibles and coinsurance amounts; and to return any money incorrectly collected.

Notices of admission and bills will be submitted to the local social security district office (see § 330). The determination of whether an emergency existed will be made by the appropriate Social Security Administration regional office with necessary medical consultation furnished by the Public Health Service. Payment of claims for emergency services will be made by intermediaries designated by the Social Security Administration.

Emergency services outside the United States are covered under limited conditions arising ordinarily only in border areas. Payment for emergency **inpatient hospital services** furnished outside the United States may be made if the individual was physi-

cally present in the United States at the time the emergency arose and the foreign hospital was substantially more accessible than the nearest U.S. hospital which was adequately equipped and available to treat the condition. Notices of admission and bills will be processed in the same manner as indicated above.

202.1 Definition of Emergency Services.—Under the health insurance program, emergency services are those outpatient hospital diagnostic services and inpatient hospital services which are necessary to prevent the death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital available and equipped to furnish such services.

Thus, the determination of emergency services depends upon two separate findings—

1. that an emergency existed with regard to the patient's condition; and
2. that diagnosis or treatment was given at the most accessible hospital available and equipped to furnish such services.

The finding of whether the patient's condition required emergency diagnosis or treatment will ordinarily be based on the physician's evaluation of the incoming patient's condition immediately upon his or her arrival at the hospital. When the examination and diagnosis of the patient is undertaken because his apparent condition is such that failure to do so immediately might threaten his life or result in serious impairment of his health, the patient may be found to require emergency examination and diagnosis. Similarly, when the attending physician in the emergency or accident room determines that the individual should be admitted to the hospital as an inpatient to prevent death or serious impairment of health, it may be determined that emergency inpatient diagnosis or treatment was required.

In some instances the emergency nature of the situation may have been assessed by a physician who attended the patient at the place where the incident necessitating hospitalization occurred (e.g., in the case of a heart attack or an automobile accident). In these cases, the attending physician who ordered the hospitalization may substantiate the fact that emergency hospitalization was necessary.

Guidelines on what constitutes "the most accessible hospital available and equipped to furnish the necessary services" are being developed and will be made available when completed.

202.2 Termination of Emergency Services.—Since payment can be made to a nonparticipating hospital only for **emergency services**, no payment can be made to such an institution for services rendered after the emergency has ended. An emergency no longer exists when it becomes safe from a medical standpoint to move the patient to a participating institution, or to discharge him, whichever occurs first. The determination that an emergency has ended will ordinarily be based upon the physician's supporting statement, discussed below, and, when appropriate, additional data furnished by the hospital, e.g., from the patient's medical record.

202.3 Physician's Supporting Statements.—Claims filed by a nonparticipating hospital for emergency services payment must be accompanied by a physician's statement describing the nature of the emergency and stating that the services rendered were necessary to prevent the death of the individual or the serious impairment of his health. A bare statement that an emergency existed is not sufficient.

The statement should describe the nature of the emergency, furnish relevant clinical information about the condition of the patient, and also state that the services rendered were required as emergency services as defined above. It must be sufficiently comprehensive to support a finding that an emergency existed. In addition, when inpatient services are involved, the statement must include the date when, in the physician's judgment, the emergency ceased.

Most emergencies will be of relatively short duration so that only one bill will be submitted in a case. Thus, generally only one physician's statement will be necessary. However, in the rare situation where an emergency exists over an extended period, requests for payment following the initial one are to be accompanied by a physician's statement containing sufficient information to indicate clearly that the emergency situation still existed. A bare statement that the emergency continues to exist would not be acceptable.

Additional information to support a finding that the services furnished were emergency services may be requested from the physician, the hospital, and others.

203. TUBERCULOSIS HOSPITAL

A tuberculosis hospital is an institution which is primarily engaged in providing by or under the supervision of a physician, medical services for the diagnosis and treatment of tuberculosis. To be eligible for participation in the program as a tuberculosis hospital, it must be accredited by the Joint Commission on Accreditation of Hospitals, have in effect a utilization

review plan, and comply with additional staffing and medical record requirements necessary to carry out an active program of treatment and intensive care. (See "Conditions of Participation for Hospitals.")

204. PSYCHIATRIC HOSPITAL

A psychiatric hospital is an institution which is primarily engaged in providing by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons. To be eligible for participation in the program as a psychiatric hospital, it must be accredited by the Joint Commission on Accreditation of Hospitals, have in effect a utilization review plan and comply with additional staffing and medical record requirements necessary to carry out an active program of treatment and intensive care. (See "Conditions of Participation for Hospitals.")

205. CERTIFICATION OF PARTS OF INSTITUTIONS AS HOSPITALS

Under certain conditions a distinct part of a psychiatric or tuberculosis institution may be certified as a psychiatric, tuberculosis, or general hospital.

205.1 Part of a Psychiatric or a Tuberculosis Institution as a Psychiatric or Tuberculosis Hospital.—A distinct part of a psychiatric or tuberculosis institution can be certified as a psychiatric or tuberculosis hospital if it meets the conditions of participation even though the institution of which it is a part does not. If the distinct part meets requirements equivalent to the accreditation requirements of the JCAH, it can qualify under the program even though the institution itself is not accredited.

205.2 General Hospital Facility of Psychiatric or Tuberculosis Hospital.—A general hospital facility within a psychiatric or tuberculosis hospital may be certified as a general hospital independent of the institution as a whole provided the general facility is a self-contained operational entity distinct from the rest of the institution. The general hospital facility would be regarded as a separate institution for this purpose since the law does not provide for certifying a "distinct part" of an institution as a general hospital.

Services furnished in a separately certified general hospital facility are not subject to any of the benefit limitations applicable to the other parts of the institution, i.e., the reduction in benefit days in the first spell of illness in the case of psychiatric and tuberculosis hospitals (§ 217) and the 190-day lifetime maximum on inpatient services in the case of psychiatric hospitals (§ 218).

205.3 Part of a General Hospital as a Psychiatric or Tuberculosis Hospital.—There is no provision for a psychiatric or tuberculosis wing of a general hospital to be certified as a psychiatric or tuberculosis hospital. The distinct part provisions apply only to psychiatric and tuberculosis institutions and not to general hospitals.

A psychiatric or tuberculosis facility which is part of a general hospital or a large medical center or complex will be included within the certification of the overall institution unless the psychiatric or tuberculosis facility operates as a separate functioning entity, i.e., it is located in a separate building, wing, or part of a building, has its own administration, and maintains separate fiscal records.

206. CHRISTIAN SCIENCE SANATORIUM

A **Christian Science sanatorium** operated or listed and certified by the First Church of Christ, Scientist, Boston, Mass., qualifies as both a **hospital** and **extended care facility**. Sanatorium services are considered to be furnished by a sanatorium in its capacity as a hospital unless the individual elects to have them treated as sanatorium extended care services. Inpatient care in such an institution whether as hospital services or extended care services can begin or prolong a "spell of illness" (§ 215).

Payment may be made to a participating sanatorium for as many as 120 days of covered Christian Science care in the same spell of illness—up to 90 days under the hospital provision and up to 30 days under the extended care provision. Payment for sanatorium extended care services may not be made for more than 30 days in each spell of illness, instead of the 100 days applicable to extended care services generally.

Payment can be made in the same spell of illness for both inpatient hospital services furnished in a hospital and those furnished by a sanatorium in its capacity as a hospital, but the total days of covered care cannot exceed the maximum of 90 days in a spell of illness (§ 216).

Payment may not be made for sanatorium extended care services after an individual has been furnished posthospital inpatient extended care services during the same spell of illness in a qualified extended care facility other than a Christian Science sanatorium. Similarly, payment may not be made for posthospital extended care services furnished to an inpatient of an extended care facility other than a Christian Science sanatorium after he has been furnished, during the same spell of illness, covered sanatorium extended care services.

207. UNDER ARRANGEMENTS

A hospital may make arrangements with others to furnish covered items or services. When such arrangements are made, receipt of payment by the hospital for the services (whether it bills in its own right or on behalf of those furnishing the services) must relieve the beneficiary or any other person of further liability.

There are additional special requirements on furnishing items and services under arrangements. These depend on the type of hospital service involved:

- a. For inpatient hospital services, see §§ 210 ff.
- b. For outpatient diagnostic services, see § 232 ff.
- c. For hospital services under medical insurance, see §§ 240 ff.

Inpatient Hospital Services

210. COVERED INPATIENT HOSPITAL SERVICES

Patients covered under hospital insurance are entitled to have payment made on their behalf on a reasonable cost basis for inpatient hospital services. An **inpatient** is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. A person is considered an inpatient if formally admitted as an inpatient with the expectation that he will remain at least overnight and occupy a bed even though it later develops that he can be discharged, or is transferred to another hospital and does not actually use a hospital bed overnight. For billing of outpatient services furnished before admission as an inpatient see § 400.

(If a patient receives items or services in excess of, or more expensive than, those for which payment can be made, payment will be made only for the reasonable cost of the covered items or services. This provision applies not only to inpatient services but to all hospital services under Parts A and B of the program.)

§§ 210.1–210.7 discuss coverage of inpatient hospital services (including psychiatric and tuberculosis hospital services).

210.1 Bed and Board in Semiprivate Accommodations.—Hospital insurance will pay for the reasonable cost of semiprivate accommodations (two-, three-, or four-bed accommodations). When accommodations other than semiprivate are furnished, the following rules will govern.

A. Private Rooms Medically Necessary.—Payment may be made for the reasonable cost of a private room or other accommodations more expensive than semiprivate only when such accommodations are medically necessary. Private rooms will be considered med-

ically necessary when the patient's condition requires him to be isolated for his own health or that of others.

The term isolation may apply when treating a number of physical and mental conditions. These include communicable diseases which require isolation of the patient for certain periods. Privacy may also be necessary for patients whose symptoms or treatment are likely to alarm or disturb others in the same room.

Payment will also be made for the use of **intensive care facilities** where medically indicated.

B. Private Rooms Not Medically Necessary.—When accommodations more expensive than semiprivate are furnished the patient because, at the time of admission, less expensive accommodations are not available, the program may pay only the reasonable cost of semiprivate accommodations. If the patient is admitted to a hospital which has only private accommodations, and no semiprivate rooms or wards exist, the program may pay only the equivalent of the reasonable cost of semiprivate accommodations, unless private accommodations were medically necessary.

When accommodations more expensive than semiprivate are furnished the patient **at his request** in the absence of medical necessity, the hospital may charge the patient no more than the difference between the customary charges for the accommodations furnished and the customary charges for semiprivate accommodations at the most prevalent rate at the time of admission. No such charge may be made to the patient unless he requested the more expensive accommodations with the knowledge that he would be charged the differential. (See D below for definitions of "customary charges" and "most prevalent rate.")

C. Wards.—When accommodations less expensive than semiprivate are furnished **at the patient's request or for a reason determined to be consistent with the purposes of the health insurance program**, payment may be made for the reasonable cost of the accommodations furnished. It is considered to be consistent with the program's purposes to furnish bed and board in less expensive accommodations where semiprivate accommodations are not available. However, the patient must be moved to semiprivate accommodations when they become available. (Payment to hospitals which have **only** ward accommodations will be made on the basis of the reasonable cost of the accommodations furnished.)

In some cases, a patient is placed in accommodations less expensive than semiprivate **neither at his request nor for a reason consistent with the program's purposes**. It is not consistent with the purposes of

the law to assign a patient ward accommodations on the basis of his social or economic status, his national origin, race, or religion, or his entitlement to benefits as a medicare patient, or any other discriminatory reason, when the patient has not requested such assignment. A hospital which repeatedly assigns patients to accommodations less expensive than semiprivate neither at the patient's request nor for reasons consistent with the purposes of the program will be subject to termination of its participation agreement.

When ward accommodations are furnished neither at the patient's request nor for a reason consistent with the program's purpose, reimbursement will be made at a reduced rate. The payment will be the reasonable cost of semiprivate accommodations minus the difference between the institution's customary charges for semiprivate accommodations at the most prevalent rate (see D below) at the time of the patient's admission and the charge customarily made for the accommodations furnished the patient by the institution. (For example, the reasonable cost of semiprivate accommodations is \$40 per day. The most prevalent customary charge rate for a semiprivate room was \$42 per day and \$35 per day the customary charge for ward accommodations. The hospital would be paid \$33 per day for the ward accommodations, i.e., \$42 minus \$35 equals \$7; \$40 minus \$7 equals \$33.) However, payment cannot be more than the reasonable cost of ward accommodations regardless of the amount indicated by the use of this formula. The reduction in payment, when appropriate, will be made at the end-of-year settlement.

D. Customary charges means amounts which the hospital is uniformly charging patients currently for specific services and accommodations. The **most prevalent rate** for semiprivate accommodations is the rate which applies to the greatest number of semiprivate beds.

210.2 Nursing and Other Services.—Nursing and other related services, use of hospital facilities, and medical social services ordinarily furnished by the hospital for the care and treatment of inpatients are covered.

If the hospital engages the services of a nurse or other nonphysician anesthetist (either on a salary or fee-for-service basis) under arrangements which provide for billing to be made by the hospital, the cost of the service when provided to an inpatient is covered under Part A.

NOTE: The services of a private-duty nurse or other private-duty attendant are not covered. Private-duty nurses or private-duty attendants are

registered professional nurses, licensed practical nurses, or any other trained attendant whose services are rendered to and restricted to a particular patient by arrangement between the patient and the private-duty nurse or attendant.

210.3 Drugs and Biologicals.—Drugs and biologicals for use in the hospital, which are ordinarily furnished by the hospital for the care and treatment of inpatients, are covered.

Two basic requirements must be met for a drug or biological furnished by a hospital to be included as a covered hospital service. The drug or biological must (1) represent a cost to the institution in rendering services to the beneficiary; and (2) either be included, or approved for inclusion, in the U.S. Pharmacopeia, the National Formulary, the U.S. Homeopathic Pharmacopoeia, or New Drugs or Accepted Dental Remedies (except for those unfavorably evaluated), or be approved by the pharmacy and drug therapeutics or equivalent committee of the medical staff of the hospital for use in the hospital.

A. Drugs Included in the Drug Compendia.—Coverage is provided only for those drugs and biologicals included, or approved for inclusion, in the latest official edition or revision of the compendia. The latest official editions are: (1) U.S. Pharmacopeia, 17th Revision, official from September 1, 1965, (2) the National Formulary, 12th Edition, official from September 1, 1965, (3) U.S. Homeopathic Pharmacopoeia, 7th Revised Edition, 1964, (4) New Drugs, 1966, and (5) Accepted Dental Remedies, 1966.

The exclusion from coverage of drugs and biologicals unfavorably evaluated in New Drugs and Accepted Dental Remedies applies to those drugs and biologicals which have been unfavorably evaluated for all medicinal uses. If a drug or biological has been unfavorably evaluated for one or more, **but not all**, medicinal uses, the exclusion applies only where the drug has been unfavorably evaluated for the medicinal use to which it is being put.

Drugs and biologicals are considered "approved for inclusion" in a compendium if approved under the procedure established by the professional organization responsible for the revision of the compendium.

B. Approval by Pharmacy and Drug Therapeutics Committee.—A pharmacy and drug therapeutics or equivalent committee is a medical staff committee which confers with the hospital pharmacist in the formulation of policies pertaining to drugs. Drugs and biologicals approved for use in the hospital by such a committee are covered only if the committee

develops and maintains a formulary or list of drugs accepted for use in the hospital. The committee need not function exclusively as a pharmacy and drug therapeutics committee; it may carry on other medical staff functions.

Drugs and biologicals are considered approved for use in the hospital if selected for inclusion in the hospital drug list or formulary under the procedure of the committee established for that purpose. Express approval is required; the fact that a drug or biological has not been specifically determined to be unacceptable for use in the hospital does not constitute approval.

Drugs and biologicals are covered if approved for general use in the hospital, or if approved for use by a particular patient or group of patients. If the pharmacy and drug therapeutics committee gives approval for use of an investigational drug in the hospital, the drug will be covered to the extent that its cost is not met by funds provided for research.

C. Combination Drugs.—Combination drugs are covered if the combination itself or all of the therapeutic ingredients of the combination are included, or approved for inclusion, in any of the designated drug compendia. Any combination drug approved for use in the hospital by the pharmacy and drug therapeutics or equivalent committee is covered.

D. Drugs Specially Ordered for Inpatients.—Coverage is not limited to drugs and biologicals routinely stocked by the hospital; a drug or biological not stocked by the hospital which the hospital obtains for the patient from an outside source, such as a community pharmacy, can also be covered.

Drugs and biologicals not included in the drug list or formulary maintained by the hospital's pharmacy and drug therapeutics committee may be covered if the hospital has a policy which permits such drugs to be furnished to a patient at the special request of a physician. However, in order to be covered, such drugs and biologicals must be included, or approved for inclusion, in one of the designated drug compendia. (In addition, a combination drug, or all of its therapeutic ingredients, would have to be included or approved for inclusion in one of the compendia.)

E. Drugs for Use Outside the Hospital.—Drugs and biologicals furnished by a hospital to an inpatient for use outside the hospital are, in general, not covered as inpatient hospital services. However, if the drug or biological is deemed medically necessary to permit or facilitate the patient's departure from the hospital, and a limited supply is required until he can obtain a continuing supply, the limited supply of the

drug or biological is covered as an inpatient hospital service.

210.4 Supplies, Appliances, and Equipment.—Supplies, appliances, and equipment which are ordinarily furnished by the hospital for the care and treatment of the beneficiary solely during his inpatient stay in the hospital are covered inpatient hospital services.

Under certain circumstances, supplies, appliances, and equipment used during the beneficiary's inpatient stay are covered even though they leave the hospital with the patient when he is discharged. These are circumstances in which it would be unreasonable or impossible from a medical standpoint to limit the patient's use of the item to the periods during which the individual is an inpatient. Examples of items covered under this rule are cardiac valves, cardiac pacemakers, and artificial limbs which are permanently installed in or attached to the patient's body while he is an inpatient of the hospital; and items, such as tracheostomy or drainage tubes, which are temporarily installed in or attached to the patient's body while he is receiving treatment as an inpatient and which are also necessary to permit or facilitate the patient's release from the hospital.

Supplies, appliances, and equipment furnished to an inpatient for use **only** outside the hospital are not, in general, covered as inpatient hospital services. However, a temporary or disposable item which is medically necessary to permit or facilitate the patient's departure from the hospital, and is required until the patient can obtain a continuing supply is covered as an inpatient hospital service.

The reasonable cost of oxygen furnished to hospital inpatients is covered under Part A as an inpatient supply.

210.5 Other Diagnostic or Therapeutic Items or Services.—Other diagnostic or therapeutic items or services ordinarily furnished inpatients by the hospital or by others under arrangements made by the hospital are covered. This category of covered services encompasses items and services not otherwise specifically listed as covered inpatient hospital services. With respect to items that leave the hospital with the patient when he is discharged, such as splints or casts, the rules for determining whether the item is covered are the same as the rules set forth above for supplies, appliances, and equipment.

When a psychologist or physical therapist is a salaried member of the staff of a hospital, his diagnostic or therapeutic services to inpatients of that hospital are covered on a reasonable cost basis in the same

manner as the services of other nonphysician hospital employees. The services of a psychologist or physical therapist who is not a salaried staff member are covered if furnished by the hospital as part of the services it ordinarily furnishes under arrangements which provide for billing to be handled by the hospital.

Diagnostic services furnished under arrangements with laboratories are covered as follows:

A. Diagnostic services furnished to an inpatient by an independent clinical laboratory under arrangements with the hospital are reimbursable under hospital insurance if the specified requirements are met. Where State or applicable local law provides for licensing of independent clinical laboratories, diagnostic services furnished by such a laboratory are covered only if the laboratory is either licensed under such law or is approved as meeting the requirements for licensing by the State or local agency responsible for licensing laboratories. Such laboratories must also meet the health and safety requirements prescribed by the Secretary of Health, Education, and Welfare. See "Conditions for Coverage of Services of Independent Laboratories."

An independent laboratory is one which is independent both of the attending or consulting physician's office and of a hospital which is participating in the program as a provider of services. A laboratory which is part of a nonparticipating hospital is considered to be an independent laboratory. The laboratory which a physician or group of physicians maintains for performing diagnostic tests in connection with his or their own practice would not be considered an "independent laboratory." An out-of-hospital laboratory is ordinarily presumed to be independent unless there is written evidence establishing that it is operated by or under the supervision of a participating hospital or its organized medical staff. A laboratory operated on the hospital's premises is ordinarily presumed to be operated by or under the supervision of the hospital or its organized medical staff, and therefore not an independent laboratory.

A clinical laboratory is a laboratory where microbiological, serological, chemical, hemotological, biophysical, cytological, immunohematological or pathological examinations are performed on materials derived from the human body, to provide information for the diagnosis, prevention or treatment of a disease or assessment of a medical condition.

B. Diagnostic services furnished a hospital inpatient under arrangements with the laboratory of another participating hospital are reimbursable

on a cost basis under Part A to the hospital obtaining the services.

NOTE: Where a hospital obtains diagnostic laboratory services for inpatients under arrangements described in § 210.5A or § 210.5B, the cost to the hospital obtaining the services would be the reasonable charge for the laboratory's service.

210.6 Services of Interns or Residents-in-Training.—Hospital insurance covers the reasonable cost of the services of interns or residents-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association.

In the case of services of interns or residents-in-training in the field of dentistry in a hospital or osteopathic hospital, the teaching program must have the approval of the Council on Dental Education of the American Dental Association.

See § 240.1 for coverage of services of hospital interns and residents under medical insurance.

210.7 Inpatient Services in Connection With Dental Services.—When a patient is hospitalized for a dental procedure and the dentist's service is covered under Part B, the inpatient hospital services furnished during the stay are covered under Part A. For example, both the professional services of the dentist and the inpatient hospital expenses are covered when the dentist reduces a jaw fracture of an individual who is an inpatient of a participating hospital. See also §§ 245, 260.12, and 274.

Where a patient is hospitalized **solely** for noncovered dental treatment (§ 260.12) neither the professional services of the dentist nor the inpatient hospital services are covered.

If a patient is hospitalized for a noncovered dental procedure, but the hospitalization is required to assure proper medical management, control, or treatment of a nondental impairment, the inpatient hospital services are covered. An example is a patient with a history of repeated heart attacks who must have all of his teeth extracted. Include an explanation when the bill is submitted. In these cases all ancillary services **furnished by the hospital**, such as x-rays, administration of anesthesia, use of the operating room, etc., are covered. See § 274 for required certification.

Regardless of whether the inpatient hospital services are covered, the medical services of physicians furnished in connection with noncovered dental services,

are not covered. Thus, the services of an anesthesiologist, radiologist, or pathologist whose services are performed in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth are not covered.

Duration of Covered Inpatient Services

215. SPELL OF ILLNESS DEFINED

A spell of illness is a period of consecutive days that **begins** with the first day (not included in a previous spell of illness) on which a patient is furnished inpatient hospital or extended care services by a qualified provider in a month for which the patient is entitled to hospital insurance benefits. A qualified provider is a hospital (including a psychiatric or tuberculosis hospital) or extended care facility that has been certified as meeting all the requirements of the definition of such an institution. A hospital which meets the requirements in § 202 is a qualified hospital for purposes of beginning a spell of illness when it furnishes the patient covered inpatient emergency services. **Thus, generally, the spell of illness begins when covered inpatient services are initially furnished to an entitled individual.**

If a person is in a nonqualified institution on the first day of his entitlement under Part A and is subsequently transferred to a qualified hospital (general, psychiatric, or tuberculosis), his spell of illness begins on admission to the qualified hospital.

Admission to a qualified extended care facility will begin a spell of illness even though payment for the services cannot be made because the prior hospitalization or transfer requirement has not been met (see § 110.2).

The spell of illness **ends** with the close of a period of 60 consecutive days during which the patient was neither an inpatient of a hospital nor an inpatient of an extended care facility. To determine the 60-consecutive-day period, begin counting with the day on which the individual was discharged. *It is important to note that for purposes of continuing a spell of illness the hospital or extended care facility in which the stay occurs need not meet all of the requirements that are necessary for starting a spell of illness.*

Inpatient services will prolong the beneficiary's spell of illness if the **hospital** meets the initial requirement of the definitions in §§ 200, 203, or 204. That is, it is primarily engaged in providing, by or under the supervision of physician(s), to inpatients (1) diagnostic and therapeutic services for medical diagnosis,

treatment, and care of injured, disabled, or sick persons, or rehabilitation services for injured, disabled, or sick persons; **or**, (2) psychiatric services for the diagnosis and treatment of mentally ill persons; **or** (3) medical services for the diagnosis and treatment of tuberculosis.

Similarly, inpatient services in an **extended care facility** will prolong a beneficiary's spell of illness if the facility (including one primarily for the care and treatment of mental diseases or tuberculosis) meets at least the requirement that it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for injured, disabled, or sick persons.

An individual may be discharged from and readmitted to a hospital or extended care facility several times during a spell of illness and still be in the same spell if 60 days have not elapsed between discharge and readmission. The stay need not be for related physical or mental conditions. As long as a person continues to be entitled to hospital insurance, there is no limit to the number of spells of illness he may have.

Example 1: X was born August 9, 1902. On July 28, 1967, X entered a participating general hospital. After he had been in the hospital for 2 weeks, X was discharged on August 11, 1967. On his doctor's orders X entered a participating nursing home on August 15, 1967, and remained there until his discharge on October 27, 1967. He had no further inpatient stays in 1967.

X's spell of illness began on August 1, 1967, the first day of the month he attained age 65 and was entitled to hospital insurance. The spell of illness ended December 25, 1967, the end of the 60-day period beginning with the date of his last discharge.

Example 2: Y, over age 65, entered a participating general hospital on July 28, 1968, for treatment of a heart condition. He was discharged on August 11, 1968. On August 20, 1968, Y entered a **nonparticipating nursing home**, which provided primarily skilled nursing care and related services. Y remained in this facility until his discharge on October 27, 1968. On December 25, 1968, Y was again admitted to a participating hospital because of injuries suffered in an accident. He was discharged on January 13, 1969, and had no further inpatient stays in 1969.

Y's spell of illness began on July 28, 1968. His stay in the nursing home began less than 60 days after his hospital stay and the spell was continued even though the stay was not covered. The subsequent hos-

pital stay began less than 60 days after the nursing home stay and continued the spell of illness, although the condition treated was unrelated to his prior stays. The spell ended on March 13, 1969, the end of the 60-day period beginning with the day of last discharge.

216. INPATIENT HOSPITAL BENEFIT DAYS

A patient having hospital insurance coverage is entitled to have payment made on his behalf for up to **90 days** of covered inpatient hospital services in each spell of illness. (For coinsurance provision, see § 225.)

216.1 Inpatient Day Defined.—The number of days of care charged to a beneficiary for inpatient hospital services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is to be used in reporting days of care for beneficiaries, even if the hospital uses a different definition of day for statistical or other purposes.

A part of a day, including the day of admission, counts as a full day. However, the day of discharge, or a day on which a patient begins a leave of absence, is not counted as a day. (Charges for ancillary services on the day of discharge are covered under the reimbursement formula.) If admission and discharge occur on the same day, the day is considered a day of admission and counts as one inpatient day. (For billing when a patient is transferred to another hospital before midnight of the day of admission, see § 402.1, Item 19, and § 410.1 Item 20.)

216.2 Late Discharge.—When a patient chooses to continue to occupy his hospital accommodations beyond the checkout time for personal reasons, the hospital may charge the beneficiary for his continued stay. Such a stay beyond the checkout time, for the comfort or convenience of the patient, is not covered under the program and the hospital's agreement to participate in the program does not preclude it from charging the patient. However, it is expected that hospitals will not impose late charges on a beneficiary unless he has been given reasonable notice (for example, 24 hours) of his impending discharge.

Where the patient's medical condition is the cause of the stay past the checkout time (e.g., the patient needs further services, is bedridden and awaiting transportation to his home or to an extended care facility, or dies in the hospital), the stay beyond the discharge hour is covered under the program and the hospital may not charge the patient.

216.3 Leaves of Absence.—The day on which the patient began a leave of absence is treated as a day of discharge and is not counted as an inpatient day unless he returns to the hospital by midnight of the same day. The day the patient returns to the hospital from a leave of absence is treated as a day of admission and is counted as an inpatient day if he is present at midnight of that day.

216.4 Discharge on First Day of Entitlement or Participation.—In the following special situations program payment is not made for accommodations on the day of discharge, but is made for ancillary services provided on that day: (a) Where a patient is admitted prior to the first day of his entitlement and is discharged from a participating hospital on the first day of his entitlement; and (b) where a patient in a non-covered stay in a nonparticipating hospital is discharged on the first day the hospital becomes a participating hospital. For a late discharge on such a day, the rules in § 216.2 will be followed. Although in these situations a day of utilization is not counted, a spell of illness begins and any charges for covered services are applied against the deductible.

217. INPATIENT TUBERCULOSIS AND PSYCHIATRIC RESTRICTION

If an individual is in a participating tuberculosis or psychiatric hospital on the first day of his entitlement to hospital insurance, the number of inpatient benefit days in his first spell of illness is subject to reduction. The days (not necessarily consecutive) on which he was an inpatient of a psychiatric or tuberculosis hospital in the 90-day period immediately before the first day of entitlement, must be subtracted from the 90 days of inpatient hospital services for which he would otherwise be eligible in his first spell of illness. Days spent in a **general hospital** for diagnosis or treatment of tuberculosis or a psychiatric condition prior to entitlement will not reduce the patient's 90 inpatient benefit days in his initial spell of illness.

When this reduction applies, it applies to all inpatient hospital services in the initial spell of illness whether received in a tuberculosis or psychiatric hospital, or in a general hospital. For example, if a patient in a psychiatric hospital has no benefit days remaining because of this reduction, a subsequent stay in a general hospital in his initial spell of illness will not be covered.

See § 225 for the effect of this provision on the coinsurance provision.

217.1 Patient Status on Day of Entitlement.—A patient who is in a participating tuberculosis or psychiatric hospital on the first day of his entitlement is

subject to the restriction. The restriction applies to patients admitted to or discharged from such a hospital on their first day of entitlement, or who begin or end a leave of absence on that day. Where only a distinct part of an institution is participating as a tuberculosis or psychiatric hospital, the provision applies only to patients who, on their first day of entitlement, are inpatients of that part.

The provision does not apply to persons who are receiving inpatient diagnostic or therapeutic services for tuberculosis or a psychiatric condition in a general hospital on their first day of entitlement. It also does not apply to patients who, on that day, are inpatients of a tuberculosis or psychiatric institution's medical-surgical facility, if that facility is participating as a general hospital (§ 205.2).

217.2 Institution's Status in Determining Days Deducted.—The status of a tuberculosis or psychiatric hospital (or a distinct part of such a hospital) as of the individual's first day of entitlement is controlling in determining whether days spent there during the preceding 90 days are to be deducted. Thus, deductions would be made for days spent in a hospital (or distinct part) which was participating as of the individual's first day of entitlement even though it was not participating during all or part of the preceding 90 days. However, where an institution is not participating as of the individual's first day of entitlement, deductions would not be made for days spent in that institution during the preceding 90 days, even though the institution is later certified for participation as a tuberculosis or psychiatric hospital.

Where a participating tuberculosis or psychiatric hospital is a distinct part of an institution, deductions are made only for days spent in the wards, floors, wings, etc., included in the participating distinct part as of the individual's first day of entitlement, even though it was not participating during all or part of the preceding 90 days. Deductions are not made for days spent in a part of the institution not included in the participating distinct part as of the individual's first day of entitlement, e.g., days spent in a custodial section of the institution or days spent in a general medical-surgical facility participating as a general hospital.

217.3 Days of Admission, Discharge, and Leave.—In determining the number of days to be deducted, include days of admission and days on which the patient returned from leave of absence. Do not count days of discharge, days on which the patient began a leave of absence, or days of leave during all of which the individual was absent from the hospital.

218. INPATIENT PSYCHIATRIC HOSPITAL SERVICES—LIFETIME LIMITATION

Payment may not be made for more than a total of 190 days of inpatient psychiatric hospital services during the patient's lifetime. **The limitation applies only to services furnished in a psychiatric hospital.** The period spent in a psychiatric hospital prior to entitlement does not count against the patient's lifetime limitation, even though preentitlement days may have been counted against the 90 days of eligibility in the first spell of illness.

219. INPATIENT SERVICES DAYS COUNTING TOWARD MAXIMUMS

Inpatient hospital (including psychiatric and tuberculosis hospital) services count toward the maximum number of benefit days payable per spell of illness only if—

A. payment for the services is made, or

B. payment for the services would be made if a request for payment were properly filed and if a physician certified that the services were necessary. Where payment cannot be made because of the inpatient deductible or coinsurance requirement, the inpatient days used in satisfying these requirements nevertheless count toward the beneficiary's maximum inpatient days.

Similiary, inpatient psychiatric hospital services count toward the 190-day lifetime limitation on inpatient psychiatric hospital services only if these conditions are met.

Inpatient Deductibles and Coinsurance

220. DEDUCTIBLE

The patient is responsible for a deductible amount of \$40 for inpatient hospital services in each spell of illness. This amount is subject to change, but not before 1969. Each year beginning in 1968, the Secretary of Health, Education, and Welfare will determine the amount of the deductible for the following year.

The deductible is satisfied only by charges for covered services. Expenses for covered services count toward the deductible on an incurred rather than paid basis. Expenses incurred in one spell of illness cannot be applied toward meeting the deductible in a later spell of illness. Expenses incurred in meeting the whole blood deductible do not count toward the inpatient hospital deductible.

A reduction in benefit days resulting from confinement in a tuberculosis or psychiatric hospital on and immediately preceding the date of entitlement (see

§§ 217 ff) does not affect the amount of the deductible for which the patient is responsible. The deductible amount remains at \$40.

If a patient has not yet met the inpatient deductible and both the customary and actual charges for the inpatient stay are less than \$40, the greater of the two will be applied toward the deductible. (See § 210.1D for a definition of customary charges.) There may be some interim reimbursement to the hospital even though the patient has not met the deductible.

Example: The total charge to the patient is \$20. Customary charge for the services \$25. The intermediary has established a reasonable cost per diem rate for the hospital of \$39.

The amount creditable to the patient's deductible, using the customary charge, is \$25. The hospital shows charges of \$25 on its bill to the program. Although the patient has met only \$25 of his \$40 deductible, the hospital receives an interim payment of \$14 (interim per diem less customary charge).

222. WHOLE BLOOD DEDUCTIBLE

A. Whole Blood Defined.—For purposes of the whole blood deductible, whole blood is human blood from which none of the liquid or cellular components have been removed. Components of blood such as packed cells, plasma, gamma globulin, etc., are not subject to the whole blood deductible. These components of whole blood are covered biologicals. (See § 210.3 for coverage of biologicals.)

B. Deductible.—Generally, in each spell of illness no payment for the first 3 pints of whole blood may be made under the program. (See C below for the exception for such blood furnished by an independent blood bank.) After the 3-pint deductible has been satisfied, the program pays the hospital's blood costs whether the blood comes from the hospital's own blood bank or is obtained from an independent blood bank.

The whole blood deductible applies only to the first 3 pints of blood furnished in any spell of illness, even though more than one provider furnishes blood. This deductible is in addition to any other applicable deductible and coinsurance amounts for which the patient is responsible.

Example: In the same spell of illness, an individual was an inpatient in hospital X and then in hospital Y. He received 2 pints of whole blood in hospital X and 4 pints in hospital Y. The whole blood deductible applies to the 2 pints furnished by hospital X and 1 of the pints furnished by hospital Y.

The patient may be charged for any of the first 3 pints of whole blood which is not replaced. The hospital can-

not charge the patient for any of the first 3 pints of blood which is replaced on a pint-for-pint basis. In billing the program, the hospital shows the **charge** for **all** unreplaced pints of blood. When program reimbursement is computed, the **cost** of **all** unreplaced blood will be reduced by the amount the hospital charged for deductible pints that were not replaced. Thus, when the charge to the patient for any of the first 3 pints not replaced exceeds the cost of the blood, program payment to the hospital will be reduced by the difference.

Example: A hospital furnished 100 pints of blood which were not replaced and for which the charge was \$15 per pint. 80 pints were covered pints and 20 pints were deductible pints for which beneficiaries were charged. On audit the cost of blood was determined to be \$10 per pint. The program reimbursement to the hospital is \$700 (the cost of all unreplaced blood, \$1,000, less the charges to beneficiaries for deductible pints not replaced, \$300).

The deductible involves only the cost of the blood itself. Costs incurred by the hospital in **administering, storing, and processing** whole blood are not part of the whole blood deductible. These costs are covered by the hospital insurance program whether or not the blood is replaced.

Example: A patient during his first stay in a spell of illness receives 5 pints of whole blood from the hospital's own blood bank. Relatives donate 3 pints on the patient's behalf. The patient may not be charged for whole blood since he replaced the first 3 pints he received. The cost of the 2 pints not replaced and the hospital's cost in administering all of the blood to the patient, in taking the blood from the donors, and in processing the blood are reimbursable under Part A.

Some hospitals customarily require replacement of blood in an amount greater than that furnished the patient. For example, a nonbeneficiary patient, furnished 3 pints of blood, is subject to a charge unless he arranges to replace 4 pints. Such a hospital is free to persuade a beneficiary to arrange for donation of more blood than was furnished to him. However, the hospital may not charge a beneficiary who fails to comply with such a request if he has replaced on a pint-for-pint basis each of the first 3 pints he received.

Where more blood is donated on behalf of a patient than is required for full replacement on a pint-for-pint basis, the value of the excess blood is not deducted from the amount payable to the hospital under Part A. However, such donations would tend to reduce the cost of blood to the hospital.

C. Provisions Applicable to Blood from Independent Blood Banks.—Where (1) a provider has furnished any of the first 3 pints of blood received by an individual under Part A during a spell of illness, and (2) this blood was obtained by the provider from an independent blood bank, and (3) the blood was replaced at least pint-for-pint on behalf of the individual, the program will pay the hospital its net cost for such blood. The hospital's net cost for such blood is the net charge of the blood bank after credit for replacement.

Payment by the program to the hospital for any of the deductible pints which the patient has replaced on a pint-for-pint basis may not exceed two-thirds of the amount the blood bank would have charged for those pints had they not been replaced. The program will not pay any of the blood bank's charge to the hospital for any of the first 3 pints not replaced.

If the hospital's charge to the patient for any of the first 3 pints not replaced exceeds the blood bank's charge to the hospital for the blood, program payment to the hospital will be reduced by the difference.

Example 1: A hospital obtains its whole blood from an independent blood bank which charges \$20 per pint with a rebate of \$10 for each pint replaced. Three pints of blood are furnished by the hospital to a patient who has met no part of the whole blood deductible. His relatives donate 2 pints of blood. The hospital may charge the patient \$20 for the pint of blood not replaced. The hospital will bill the program for \$20 as its net cost for the 2 pints replaced.

Example 2: Same facts as Example 1 except that the patient's relatives donate 4 pints of blood. The patient's deductible is satisfied in this case and he is not responsible for any whole blood charges. The hospital's net cost for the blood furnished the patient is again \$20. (Blood bank charges for 3 pints—\$60, less bank's rebate for 4 pints donated—\$40.)

D. Volunteer Blood Banks.—When blood is furnished by a volunteer blood bank at no charge to the hospital, it will be considered as replaced blood for purposes of meeting the whole blood deductible.

If the blood bank makes a service charge which applies whether or not the blood is replaced, this charge will be considered a covered hospital cost. However, where the service charge is made only for unreplaced blood, the charge applicable to deductible pints not replaced will be the responsibility of the patient as a charge for blood.

225. COINSURANCE

The patient is responsible for a coinsurance amount, initially \$10 (one-fourth of the inpatient hospital deductible), for each day after the 60th day and through the 90th day of inpatient hospital services furnished during a spell of illness.

Where the actual charge to the patient is less than \$10 per day, the coinsurance is the actual charge per day. In billing both the patient and the program, the coinsurance amount is the same. *

When preentitlement days of hospitalization in a tuberculosis or psychiatric hospital are counted toward the 90-day limit on inpatient hospital days in the initial spell of illness (see § 217), these preentitlement days are charged first against coinsurance days.

Example: An individual was an inpatient of a tuberculosis hospital on 15 days (counting days of admission but not days of discharge) of the 90 days prior to October 1, 1966, the date he became entitled to hospital insurance. He was an inpatient of this hospital on October 1, 1966, and continued to be hospitalized. Although he was not entitled to benefits prior to October 1, the 15 days of hospitalization prior to entitlement count toward the 90-day limit on inpatient services for the spell of illness beginning October 1, 1966. Following the rule stated above, the 30 coinsurance days available were reduced by 15, while, in this case, full benefit days were unaffected. His responsibility for the \$10 per day coinsurance began November 30, 1966, which is the 61st day in the spell of illness begun on October 1, 1966. He then had only 15 days remaining in that spell of illness for which payment could be made for inpatient hospital services, and to which the coinsurance amount would apply.

Outpatient Hospital Services

230. OUTPATIENT HOSPITAL SERVICES—GENERAL

A **hospital outpatient** is a person who has not been admitted by the hospital as an inpatient and who is not lodged in the hospital while receiving outpatient hospital services. (For definition of "inpatient," see § 210.)

Where a hospital uses the category "day patient," i.e., an individual who receives hospital services during the day and is not expected to be lodged in the hospital at midnight, the individual is classified as an outpatient. For billing of outpatient services furnished before admission as an inpatient see § 400.

Hospitals provide two distinct types of services to outpatients, namely (1) services that are diagnostic in

nature, and (2) other services which aid the physician in the treatment of his patient. The outpatient hospital diagnostic services are covered under Part A. All other hospital services provided on an outpatient basis which are incident to physicians' services rendered to outpatients are covered under Part B. The hospital is reimbursed for both types of services on a reasonable cost basis.

230.1 Rules for Distinguishing Outpatient Hospital Services.—Outpatient hospital services covered under Parts A and B must be separately identified. However, since a patient may receive services covered under both Parts A and B during a single visit to the outpatient department, questions may arise about how to classify a particular service.

If the physician designates certain services as being for diagnostic purposes and separates them from services that are not diagnostic, the hospital may accept these designations. Normally, however, the physician does not separate the services and need not be asked to do so. Where such a separation of services is not made, hospital and intermediary personnel should use the following rules in deciding how to allocate services to Parts A and B:

A. Any diagnostic laboratory test or other identifiable diagnostic test furnished by the hospital (or under arrangements as described in § 232) and normally identified as such for billing purposes, will be billed to Part A. **Any services which can be billed to Part A under this rule must be so billed.** (Outpatient diagnostic services are described in §§ 232 ff. and coverage under Part A and Part B in §§ 236 and 240.2.)

B. All other clinic services and emergency services (even though they may contain some diagnostic implications but are not normally identified as diagnostic services) will be billed to Part B. (Other outpatient hospital services are described in § 234, and in greater detail in §§ 240 ff.)

232. OUTPATIENT DIAGNOSTIC SERVICES

A service may be regarded as "diagnostic" if it is an examination or procedure to which the patient is subjected, or which is performed on materials derived from the patient, to obtain information to aid in the assessment of a medical condition or the identification of a disease. Among these examinations and tests are diagnostic laboratory services such as hematology and chemistry, diagnostic x-rays, isotope studies, EKG's, pulmonary function studies, thyroid function tests, psychological tests and other tests given to determine the nature and severity of an ailment or injury.

When furnished by the hospital, diagnostic services, including the services of nurses, psychologists, physical therapists, and technicians, and the use of supplies and equipment are covered under Part A. When a hospital sends hospital personnel and hospital equipment to a patient's home to furnish a diagnostic service, the service is covered under Part A as if the patient had received the service in the hospital outpatient department.

Hospital personnel may provide diagnostic services outside the hospital premises without the direct personal supervision of a physician. For example, if a hospital laboratory technician is sent by the hospital to a patient's home to obtain a blood sample for testing in the hospital's laboratory, the technician's services would be a covered hospital service under Part A regardless of the fact that a physician was not with the technician. (See § 240.2.A for coverage under Part B of therapeutic services furnished outside the hospital premises.)

Where the hospital makes arrangements with others for diagnostic services, such services are covered under Part A only if they are provided (1) in the hospital (e.g., through lease agreement), or (2) by another facility operated by or under the supervision of the hospital or its medical staff. Where the hospital bills for diagnostic services provided by qualified facilities which do not meet these requirements, payment can be made to the hospital under Part B subject to the conditions in § 232.2 and § 232.3 below.

232.1 Types of "Arrangements."—Hospitals currently maintain a variety of relationships with other laboratories for the purpose of supplementing their own facilities in providing diagnostic laboratory services to their patients. Some hospitals rely routinely on independent laboratories; some obtain their services only occasionally.

232.2 Diagnostic Services Obtained from "Independent" Laboratories.—Where a hospital obtains laboratory services for its outpatients under arrangements with an independent laboratory, reimbursement will be made to the hospital on a cost basis under the provisions of Part B. The laboratory must meet the requirements in § 210.5A.

232.3 Diagnostic Services Obtained Under Arrangements With Another Hospital's Laboratory.—Diagnostic laboratory services obtained for a hospital outpatient under arrangements with the laboratory of another participating hospital are reimbursable to the first hospital on a cost basis under Part B; i.e., the services were furnished in a facility not op-

erated by or under the supervision of the first hospital or its organized medical staff.

NOTE: Where a hospital obtains diagnostic laboratory services for outpatients under arrangements described in § 232.2 or § 232.3, the "cost" to the hospital which obtains the services is the reasonable charge by the laboratory.

234. OTHER OUTPATIENT HOSPITAL SERVICES WHICH AID THE PHYSICIAN

The services, other than diagnostic services, which hospitals provide on an outpatient basis generally relate to the services that aid the physician in the treatment of his patients. Such services, which include clinic services and emergency services, are covered under Part B.

Special items and services which are covered when furnished during a visit to the clinic include, for example, the services of nurses, psychologists, and technicians; use of emergency room; medical supplies such as gauze, dressings, oxygen, ointments, splints, braces, and other supplies used by the physician in treating the patient; drugs and biologicals which cannot be self-administered; radiology treatments; and special therapy treatments. See also § 240.1.

Outpatient Hospital Diagnostic Services Under Hospital Insurance

236. COVERED OUTPATIENT DIAGNOSTIC SERVICES

A patient with hospital insurance coverage is entitled to have payment made for outpatient hospital diagnostic services. (Outpatient diagnostic services are on a 20-day diagnostic study basis and are not related to a spell of illness.) These services include:

A. Diagnostic tests and related services to the extent they would be covered if performed on an inpatient basis;

B. Drugs and biologicals necessary for diagnostic study (see § 210.3 for definition of drugs and biologicals);

C. The services rendered in connection with a diagnostic study by an intern or resident-in-training in an approved teaching program (if not under an approved teaching programs, see § 240.1C);

D. Other services and supplies if customarily furnished to outpatients for purposes of diagnostic studies.

If the beneficiary has coverage only under the medical insurance plan, payment for diagnostic services can be made under Part B. (See § 240.2 for Part B diagnostic services.)

236.1 Outpatient Hospital Diagnostic Study Period.—A diagnostic study is a period of 20 consecutive days beginning with the first day on which the patient is furnished outpatient hospital diagnostic services. The diagnostic services furnished during a single study must be furnished by (or under arrangements made by) the same hospital.

A subsequent study may not begin in (or under arrangements made by) the same hospital until the prior study has been completed. However, two or more studies may be conducted at the same time in different hospitals.

The study ends after 20 days regardless of the number of days on which diagnostic services were actually furnished. Diagnostic services which continue beyond 20 days are considered to be in a new study period and must be separately billed.

236.2 Deductible for Outpatient Hospital Diagnostic Services.—The deductible for outpatient hospital diagnostic services for each 20-day diagnostic study period is \$20 (i.e., one-half of the inpatient hospital deductible). This deductible amount counts as an incurred Part B expense for individuals having medical insurance coverage. (See §§ 245–248 for explanation of supplementary medical insurance incurred expenses, deductible, coinsurance, and relation to the Part A outpatient diagnostic deductible.)

236.3 Coinsurance for Outpatient Hospital Diagnostic Services.—After satisfying the deductible, the patient is responsible for a coinsurance amount equal to 20 percent of the reasonable or the customary charges, whichever is less, for the diagnostic services rendered during the diagnostic study.

Hospital Services Covered Under Supplementary Medical Insurance

240. COVERAGE OF HOSPITAL SERVICES UNDER SUPPLEMENTARY MEDICAL INSURANCE—GENERAL

The supplementary medical insurance program provides payment for physicians' services and certain other specified health services and supplies unless such services or supplies would otherwise constitute inpatient hospital services, extended care services, or home health services. For example, Part B payment may not be made to a hospital for diagnostic x-rays, laboratory services, x-ray therapy, or other services furnished to inpatients (see § 240.1A for an exception for interns and residents).

This is true even when no Part A benefit is payable, i.e., the inpatient has exhausted his 90 days of coverage in a spell of illness; the services do not meet the special requirements for coverage in a psychiatric or tuberculosis hospital; or the hospital is not participating.

The only medical services and supplies furnished by a hospital for which payment may be made under Part B are those discussed in §§ 240.1 to 240.4.

240.1 Services of Interns and Residents.—Services performed by interns and residents—including physicians employed by a hospital who are authorized to practice only in a hospital setting—are reimbursable to the hospital on a reasonable cost basis even though the intern or resident is also a licensed physician. Services of interns and residents covered under Part B include:

A. The medical and surgical services performed for hospital inpatients by interns and residents who are not under approved teaching programs;

B. The diagnostic medical and surgical services performed in hospital outpatient departments by interns and residents not under an approved teaching program;

C. The medical and surgical services (other than diagnostic services) performed in hospital outpatient departments by interns and residents regardless of whether they are under an approved teaching program.

See § 210.6 (inpatient hospital) and § 236C (outpatient hospital diagnostic) for description of coverage under Part A of other services which interns and residents-in-training perform.

240.2 Hospital Services and Supplies Incident to Physicians' Services.—Payment may be made under the supplementary medical insurance plan for hospital services and supplies (including drugs and biologicals which cannot be self-administered) which are incident to physicians' services rendered to outpatients (see § 245 for definition of physician).

A. Hospital Services Incident to Physicians' Services.—All services provided by the hospital in connection with the physician's diagnosis or treatment of outpatients are covered under Part B as incident to physicians' services (unless otherwise specifically excluded). This includes the use of the hospital's facilities, and the services of nurses, nonphysician anesthetists, psychologists, technicians, therapists (including physical therapists), and other aides. There is no requirement that the physician who orders the hospital services be directly connected with the department which provides the services. When such hospital services are diagnostic, they are covered under Part A

(see § 232); all other services are covered under Part B.

If hospital personnel provide therapeutic services outside the hospital premises, the services are covered under Part B as incident to physicians' services only if there is direct personal supervision by a physician. For example, if a hospital therapist goes to a patient's home to give treatment and no physician accompanies him, the therapist's services would not be covered. (Such a service would be covered as a home health service if provided as part of a home health plan under arrangements with a home health agency.)

See § 232 for coverage under Part A of outpatient diagnostic services furnished outside the hospital.

Generally, the only services provided in the outpatient department of a hospital which are not covered under Part B as incident to physicians' services (aside from diagnostic services covered under Part A) are those which do not require participation by hospital personnel acting under specific order by a physician. For example, a hospital may make certain equipment, such as an intermittent positive pressure breathing machine or exercise equipment, available to the patient who is able to use it without assistance or instruction.

B. Hospital Supplies Incident to Physicians' Services.—All supplies provided by the hospital which are necessary and incident to physicians' services rendered to hospital outpatients are covered under Part B, e.g., oxygen, surgical supplies, dressings, and splints, casts, and other devices used for reduction of fractures and dislocations. The following are some additional examples of hospital supplies which are incident to physicians' services:

1. **Drugs and biologicals** of the type which cannot be self-administered are covered under Part B when furnished to outpatients as incident to physicians' services. Generally, they are limited to those administered by injection, including those required on a continuing basis, such as for pernicious anemia or arthritis. However, if the injection is of the type commonly self-administered, such as insulin injections, the drug or biological is excluded unless administered to the patient in an emergency situation. (For definitions of drugs and biologicals and combination drugs, see § 210.3.)

Whole blood administered to outpatients is covered under Part B as a biological which cannot be self-administered. Reimbursement is not subject to the whole blood deductible (see § 222).

Payment may not be made under either Part A or Part B for immunizations, i.e., vaccination or inoculation against diseases such as smallpox, polio, diphtheria,

etc. "Immunization" for this purpose, however, does not include a vaccination or inoculation related to the treatment of a particular injury or direct exposure, e.g., antirabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin. When furnished under these circumstances to a hospital outpatient as an incident to a physician's service, the vaccination or inoculation is covered under Part B.

2. Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) and replacements or repairs for such devices are covered. For example, dialysis equipment used in the treatment of renal failure is covered under Part B as a prosthetic device which replaces the function of a kidney. The term "internal body organ" includes the lens of an eye and all or part of an ear or nose. Prostheses replacing the lens of an eye include postsurgical lenses customarily used during convalescence from eye surgery in which the lens of the eye was removed. In addition, permanent lenses required by an individual lacking the organic lens of the eye, whether by surgical removal or congenital absence, are also covered.

3. Leg, arm, back, and neck braces, trusses, and artificial legs, arms and eyes.—These appliances are covered under Part B when furnished incident to physicians' services or on a physician's order. A brace includes rigid and semirigid devices which are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. Back braces include, but are not limited to, special corsets, sacroiliac, sacrolumbar, dorsolumbar corsets and belts. A terminal device (e.g., hand or hook) is covered when an artificial arm is required by the patient.

Purchase of the initial artificial limb or other appliance, or replacement of it when worn out or unrepairable is covered. The replacement of usable appliances or artificial limbs required because of a change in the patient's physical condition is also covered when supplied on a physician's order. Repairs to and adjustments of such appliances are also covered even when the appliance had been in use before the user enrolled in the supplementary medical insurance program.

240.3 Use of Durable Medical Equipment.—Durable medical equipment is equipment which can withstand repeated use and which generally does not have a value to the patient in the absence of an illness or injury. It includes such items as iron lungs, oxygen tents, oxygen regulators, intermittent positive pressure

breathing machines, hospital beds, wheelchairs, and other ambulation devices such as crutches and walkers. It must be for use in the patient's home or in a place used as his home.

In the rare situation where hospitals may furnish durable medical equipment to a beneficiary for use in his home, the use of the equipment would be an allowable hospital cost, e.g., depreciation, administrative costs involved, etc.

Reimbursement cannot be made to a beneficiary for the purchase of durable medical equipment.

When oxygen is essential for the effective use of the hospital's durable medical equipment in the patient's home, the oxygen and its container are covered. Oxygen used with equipment owned by the beneficiary is not covered. Oxygen and its container used independently of durable medical equipment is covered only as a medical supply, and therefore, only when furnished incident to a physician's professional service. Medications used with durable medical equipment are not covered.

240.4 Ambulance Service.—Ambulance service is covered only under Part B. The cost of oxygen and its administration furnished in connection with and as part of the ambulance service is also covered. (See § 280 for the required certification for ambulance service.)

An ambulance is a specially designed or equipped automobile or other vehicle (in some areas of the United States this might be a boat or plane) for transporting the sick or injured. It must have customary patient care equipment including a stretcher, clean linens, first aid supplies, oxygen equipment, and any safety and lifesaving equipment required by State or local authorities.

Personnel whose duties involve the care or handling of the patient while providing ambulance service must have adequate training in the application of first aid, i.e., training which is at least equivalent to the training provided by the standard and advanced Red Cross first aid courses. The driver does not have to meet the first aid training requirement if there is at least one other person assigned to the ambulance who has had the required training. Training "equivalent" to the standard and advanced Red Cross first aid training courses includes ambulance service training and experience acquired in military service, successful completion by the individual of a comparable first aid course furnished by or under the sponsorship of State or local authorities, an educational institution, a fire department, a hospital, a professional organization, or other

such qualified organization. On-the-job training involving the administration of first aid under the supervision of or in conjunction with trained first aid personnel for a period of time sufficient to assure the trainee's proficiency in handling the wide range of patient care services that may have to be performed by a qualified attendant can also be considered as "equivalent training."

A. **For coverage of ambulance services** each of the following three conditions must be met:

1. The vehicle used to provide the ambulance service and the ambulance personnel whose duties involve care of the patient meet the requirements specified above.

2. Ambulance service is covered only where the use of any other method of transportation is medically contraindicated by the patient's condition. (In any case in which some means of transportation other than an ambulance could be used without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance service.)

3. The patient must have been transported to the nearest hospital with appropriate facilities or to one in the same locality, **and under similar restrictions**, from one hospital to another, or to an extended care facility. The patient may, likewise, be transported from one of these institutions to his home (or place of residence) if his home is within the locality of the institution.

The requirement that a patient be transported to the **nearest hospital with appropriate facilities** or to one in the **same locality** as that hospital (and under similar restrictions from one hospital to another, to the patient's home, or to an extended care facility) is intended to provide coverage of essential ambulance service, without imposing an arbitrary "mileage" limitation. It is not contemplated, however, that payment would be made for ambulance services that involve transporting the patient beyond the locality even if the patient is transported to a participating hospital or extended care facility. The term **locality**, with respect to ambulance service, means the service area in the geographic territory surrounding the institution from which individuals normally come or are expected to come for medical services.

The term **appropriate facilities** means that the institution has available the services, supplies, and staff necessary to provide the medical care called for by the patient's injury or illness. The fact that a more distant institution is better equipped, either

qualitatively or quantitatively, to care for the patient does not warrant a finding that a closer institution does not have "appropriate facilities." However, a patient need not necessarily be taken to the nearest hospital or facility with appropriate facilities; he can be taken to another hospital or facility in the same locality.

B. **Transportation by ambulance to a hospital to obtain home health services** not available to the individual in his home is covered as a Part B service only if the three conditions in A above are met. Such transportation is not covered as a home health service.

Supplementary Medical Insurance— Deductible and Coinsurance

245. INCURRED EXPENSES

The supplementary medical insurance plan (Part B) includes coverage for expenses incurred in connection with:

1. **Physician services**, including surgery, consultation, and home, office, and institutional calls.

Physician means a doctor of medicine or osteopathy (including osteopathic practitioner) legally authorized to practice by a State in which he performs this function.

A doctor of dental surgery or dental medicine with State authorization to practice is also a physician but only for surgery related to the jaw or any structure contiguous to the jaw, or the reduction of a fracture of the jaw or any facial bone. The coverage or exclusion of any given dental service is determined by the nature of the service, and not whether it was furnished by a dentist or a doctor of medicine. (See §§ 210.7 and 260.12 for additional information on covered and excluded dental services.)

The services performed by physicians within these definitions are subject to any limitations imposed by the State on the scope of practice.

Regardless of the actual expenses for physician services incurred in the treatment of mental, psychoneurotic, or personality disorders of persons who are not inpatients of hospitals, the amount of such expenses that can be counted in a calendar year is limited to the lesser of \$312.50 or 62.5 percent of the actual expenses. This limitation does not apply to **provider** services furnished in connection with the treatment of mental, psychoneurotic, or personality disorders.

2. **Services and supplies** furnished incident to a physician's services of the kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in physicians' bills.

3. **Home health services** for up to 100 visits during a calendar year. (These are in addition to the 100 visits payable under hospital insurance.)

4. **Outpatient diagnostic service deductibles** imposed under the hospital insurance plan (Part A) for diagnostic studies during the calendar year. (See § 248 for further explanation of the outpatient hospital diagnostic deductible as an incurred expense under supplementary medical insurance.)

5. **Other medical and health services.**

246. DEDUCTIBLE

In each calendar year a deductible of \$50 must be satisfied before payment can be made under the supplementary medical insurance plan. Under a carry-over provision, expenses incurred in the last 3 months of the previous year **which were applied toward the medical insurance deductible for that year**, may also be applied against the deductible for the current year. Except to the extent that the prior year's expenses are counted, the deductible is satisfied by the initial medical insurance expenses incurred in the current year.

Bills count toward the deductible on the basis of incurred, rather than paid expenses. Noncovered expenses do not count toward the deductible. Even though an individual is not eligible for the entire calendar year, i.e., his insurance coverage begins after the first month or he dies before the last month of the year, he is still subject to the full \$50 deductible. Medical expenses incurred in the portion of the year preceding entitlement to medical insurance may not be credited toward the deductible.

247. COINSURANCE

After the deductible has been satisfied providers will be paid 80 percent of the reasonable costs, and physicians and other suppliers 80 percent of the reasonable charges, incurred during the balance of the calendar year. When payment is made on the patient's behalf, the patient is responsible for a coinsurance amount equal to 20 percent of the reasonable charges for the items and services furnished.

248. OUTPATIENT HOSPITAL DIAGNOSTIC DEDUCTIBLE AS AN INCURRED EXPENSE UNDER THE SUPPLEMENTARY MEDICAL INSURANCE PLAN

The amount of any outpatient hospital diagnostic services deductible(s) (§ 236.2) incurred by an individual during the calendar year under hospital insur-

ance, is included as an incurred expense under supplementary medical insurance. It may be used to help satisfy the medical insurance deductible, and it is reimbursable under medical insurance if that deductible has been satisfied. Payment for this incurred expense, or crediting it toward the Part B deductible, is a responsibility of the hospital insurance intermediary.

The outpatient diagnostic deductible is the only exception to the rule that payment for services may not be made under medical insurance if the patient was entitled (except for the deductibles and coinsurance) to have payment made for those services under hospital insurance.

A hospital need not charge the full amount of the Part A outpatient hospital diagnostic deductible if the patient has already satisfied the \$50 Part B deductible. The hospital's record may indicate that the Part B deductible is met, or the patient may have a utilization notice (see § 304) which shows this. The hospital would charge the patient only 20 percent of his total bill for the study, and any other outpatient services furnished. The outpatient diagnostic deductible will be considered a medical insurance item and the hospital will be reimbursed for 80 percent of it under Part B.

If the hospital collects the full amount of the outpatient diagnostic deductible from the patient because it is not aware that the Part B deductible has been met, the intermediary will reimburse the patient for 80 percent of the Part A deductible amount he paid. (See § 420 for billing information and examples.)

Hospital-Based Physicians

255. HOSPITAL-BASED PHYSICIANS' SERVICES

The medical insurance program covers the reasonable charges for physicians' services rendered to individual beneficiaries. (The services of interns and residents, however, are reimbursable to the hospital on a reasonable cost basis even though the intern or resident is a licensed physician.) The charges of hospital-based physicians (e.g., those on salary) for services directed to the medical care of the individual patient, must be specially billed either by the physician or by the hospital on his behalf. However billed, reimbursement is made for medical services to individual patients on a reasonable charge basis by the supplementary medical insurance (Part B) intermediary.

(See § 430 for billing by the hospital for these services.)

Hospital-based physicians often perform services other than those clearly directed to the medical care of individual patients. These may involve teaching, autopsy, and administrative services, and other services that benefit the hospital's patients as a group. Such physician services, not directly related to an individual patient, if compensated, must be considered in computing reimbursable hospital costs and will be reflected in amounts payable to the hospital under Part A for such services rendered program beneficiaries.

Detailed information on reasonable cost and charge computation is contained in "Principles of Reimbursement for Services by Hospital-Based Physicians." These principles establish the criteria for distinguishing between the services of hospital-based physicians which are reimbursable as provider services and those services reimbursable as physicians' services to patients.

The principles also establish a basis for determining the reasonable charges for physicians' services to patients where, under the existing arrangement between the hospital and the physician, billings to patients have not separately identified charges for these services. Where charges for physicians' services to patients have been identified separately, the customary charges for physicians' services have been established and afford a basis for determining the reasonable charges for such services.

Finally, the principles establish a basis for ascertaining the customary charges for a physician's services to patients where, under a previous arrangement between the hospital and the physician, these services were not separately identified, but this arrangement is modified to provide for separate billing.

The hospital's Part A intermediary will obtain from the hospital information it and the Part B carrier need to make payment determinations for the services of hospital-based physicians. The Part A intermediary is responsible for reviewing and approving the reasonableness of the agreement between hospital and physician on the allocation of physician compensation, received from or through the hospital, between (1) the portion attributable to provider services, i.e., services to the institution and (2) the portion attributable to physician services, i.e., identifiable services rendered by the physician to individual patients.

If the hospital and physician fail to agree or if their agreement appears unreasonable, the Part A intermediary and the Part B carrier will jointly assist in resolving the issue. The Part B carrier is responsible

for review and approval, in accordance with the applicable principles, of the basis for Part B charges for services of hospital-based physicians, i.e., the schedule of such charges if the item-by-item method of determination is used, or the uniform percentage if the optional method of determination is used.

General Exclusions From Coverage

260. GENERAL EXCLUSIONS

No payment can be made under either the hospital insurance or supplementary medical insurance programs for the following items and services.

260.1 Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are not covered. Potential personal comfort items and services such as massages and heat lamp treatments are not covered unless they contribute meaningfully to the treatment of an illness or injury, or the functioning of a malformed body member.

260.2 Items and Services for Which There is No Legal Obligation to Pay.—Free services are excluded from coverage, e.g., free chest x-rays provided by health organizations.

This exclusion does not apply if the patient has a legal obligation to pay, or some other person or organization has a legal obligation to pay for or provide the items or services. Thus, benefits for covered items and services would be paid by the program even though the same services were covered by a prepayment plan or health insurance policy. Such a plan may pay money toward the cost of services or it may maintain its own facilities and professional supporting staff.

A legal obligation to pay exists even when reimbursement is expected only to the extent of the patient's insurance coverage.

In applying this exclusion the determining factor is that there is no legal obligation to pay for the items or services, and not merely the fact that the patient is not charged because of other considerations. This exclusion, therefore, does not prohibit program payment for services rendered to:

A. **Members of religious** orders who are not charged because of a vow of poverty;

B. **Indigents** who because of their inability to pay are not charged by an institution which customarily charges for such services;

C. **The patient whose need for services resulted from the act or negligence of another** who

is or may be legally liable for the patient's medical expenses. The existence of a third person's liability does not affect the patient's obligation to pay for the services he receives;

D. Certain residents of homes for the aged.—Coverage of health services furnished to a resident of a home for the aged depends on the agreement under which the services are provided.

1. The typical relationship between the **proprietary or profit-making home** and the residents is contractual. The home agrees to furnish or pay for certain services, including specified health services, in return for specified payments by the resident. Payment can be made under the health insurance program for the specified health services received by the resident of such a home since the home has a legal obligation to pay for or provide the services. Of course, payment may also be made for covered services not included in the resident's contract with the home, which he himself has a legal obligation to pay.

2. **Nonprofit homes** are generally operated by religious or fraternal organizations. The resident is ordinarily required to contribute to the cost of his maintenance and health care to the extent that he is able. For example, the resident is usually required to assign to the home assets or income at the time of admission. Where this is the case, payment can be made under the program for covered services furnished the resident whether or not his circumstances permitted him to pay anything for his care.

However, where all services are furnished by the home on a purely charitable basis (i.e., no payment is accepted from residents regardless of their ability to pay), payment could not be made under the health insurance program for items and services furnished by the home. In this situation, however, payment could be made for services furnished by a source independent of the home if that source customarily charges for such services. Thus, payment could be made for services furnished by a hospital or extended care facility to which a resident of the home is sent, or for home health services furnished by an agency, or for the services of a physician who is not an employee of the home.

3. **Certain union homes** accept no payment from residents regardless of their ability to pay. Payment may, nevertheless, be made for services provided by such homes where admission to the home and access to the services is a matter of right for union members who meet the necessary qualifications.

4. Homes for Members of Religious Orders.—Many religious orders maintain homes similar to retirement homes to care for members who become ill or infirm. Since members of the order are under a vow of poverty, there is no charge made by the home for this care. The order is considered to have an obligation to care for its members who have rendered lifelong services. Payment may be made for services furnished in these homes, whether they are furnished by the home itself or by independent sources that customarily charge for their services.

260.3 Items and services which are paid for by a governmental entity other than under a title of the Social Security Act, such as a medical assistance program, or under a health benefits or insurance plan for employees of the governmental entity are not covered. (Payment cannot be made under the health insurance program if the services are paid for by a National Institutes of Health grant or by the Veterans Administration Home Town Care Medical Program. However, when the option to have payment made under the health insurance program is exercised, the fact of eligibility under these other programs does not prevent payment under health insurance.) The Secretary of Health, Education, and Welfare may specify other exceptions to this exclusion. The Secretary has approved payment for covered items and services even though provided free:

A. If furnished by participating State or local government-operated hospitals, including psychiatric and tuberculosis hospitals which serve the general community. Payment may not be made for services in hospitals which serve only a special category of the population, such as prison hospitals, nor for services furnished to prisoners in hospitals serving the general community.

B. If paid for by a State or local governmental entity and furnished an individual as a means to control infectious diseases or to provide for the medically indigent. These services need not be furnished in a hospital. Payment may be made for items and services furnished by a government-operated home for the indigent aged whether supplied directly by the home or purchased by it from independent physicians and hospitals. Payment may also be made for services furnished by a participating State-operated Veterans' Home and Hospital, provided the patient would, in the absence of program coverage, have been charged for the items and services, or he was admitted to the facility without charge as an indigent.

260.4 Items and services which are not provided within the United States are not covered (except for emergency inpatient hospital services furnished outside the United States under the conditions described in § 202 and payment on behalf of railroad beneficiaries for covered hospital insurance services furnished in Canadian hospitals). The United States includes the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

260.5 Items and services which are required as a result of war, or an act of war, occurring after the effective date of the patient's current coverage are not covered.

260.6 Personal Comfort Items.—Items which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member are not covered.

Charges for special items requested by the patient such as radio, television, telephone, air conditioner, and beauty and barber services are excluded from coverage.

Basic personal services such as simple barber, and beautician services (e.g., shaves, haircuts, shampoos, and simple hair sets) which patients need and cannot perform for themselves may be viewed as ordinary patient care when furnished by a long-stay institution. Such services are covered costs reimbursable under Part A when included in the flat rate charge and provided routinely without charge to the patient by a psychiatric or tuberculosis hospital. Maintenance of at least a minimum level of personal hygiene, decency, and presentability is essential to the well-being of the patient himself and of other patients who must associate with him. However, under the personal comfort exclusion, more elaborate services, such as professional manicures, hair styling, etc., are excluded even when furnished routinely and without special charge. The patient may be billed for such services if he requested the service with knowledge that he will be charged a specified amount.

260.7 Routine Physical Checkups; Eyeglasses and Eye Examinations for the purpose of prescribing, fitting, or changing eyeglasses; **Hearing Aids and Examinations for Hearing Aids**; and **Immunizations** are not covered.

Routine physical checkups include (a) examinations performed without relationship to treatment or diagnosis of a specific illness, symptom, complaint, or injury, and (b) examinations required by third parties

such as insurance companies, business establishments, or Government agencies.

The exclusions apply to eyeglasses or contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors. The exclusions do not apply to services performed in conjunction with an eye disease, as for example glaucoma or cataracts, or to postsurgical prosthetic lenses which are customarily used during convalescence from eye surgery in which the lens of the eye was removed, or to the permanent prosthetic lenses required by an individual lacking the organic lens of the eye, whether by surgical removal or congenital absence. Such prosthetic lens is a replacement for an internal body organ—the lens of the eye. (§ 240.2B2.)

Vaccinations or inoculations are excluded as “immunizations” unless they are directly related to the treatment of an injury or direct exposure such as anti-rabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin.

260.8 Orthopedic Shoes or Other Supportive Devices for the Feet.—The exclusion of orthopedic shoes does not apply to such a shoe if it is an integral part of a leg brace.

260.9 Custodial care is not covered. See § 261 ff. for definition of custodial care and its application to inpatient services.

260.10 Cosmetic Surgery or Expenses Incurred in Connection With Such Surgery are not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, nor to surgery for therapeutic purposes, which coincidentally also serves some cosmetic purpose.

260.11 Charges Imposed by Immediate Relatives of the Patient or Members of His Household are not covered.—The intent of this exclusion is to bar medicare payment for items and services which would ordinarily be furnished gratuitously because of the relationship of the beneficiary to the person imposing the charge.

A. Immediate relative, for the purpose of this exclusion, means spouse, father, mother, son, daughter, brother, or sister—whether by blood or marriage or adoption. Thus, the following degrees of relationship are included within the definition: (1) Husband and wife; (2) natural parents, children, and siblings; (3) adopted children and adoptive parents; (4) stepparents, stepchildren, stepbrothers, and stepsisters; (5) father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law.

Additionally, the intent of this exclusion extends to a grandparental relationship.

B. Members of the patient's household means those persons sharing a common abode with the patient as part of a single family unit, including those related by blood or marriage; domestic employees and others who live together as part of a single family unit. A mere roomer or boarder is not included.

Where a business enterprise imposes the charge, the exclusion applies, if the firm in fact represents an individual within these relationships. If an individual proprietorship is involved, the proprietor will be considered the individual imposing the charge. Charges imposed by a partnership do not fall within the exclusion unless all of the partners are within the designated relationships to the patient. A corporation is a separate legal entity which cannot be a member of a household or an immediate relative.

260.12 Items and services in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth are not covered. "Structures directly supporting the teeth" means the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth, and alveolar process.

Payment may be made, however, for (a) surgery related to the jaw or any structures contiguous to the jaw, or (b) the reduction of any fracture of the jaw or any facial bone, including dental splints or other appliances used for this purpose.

The hospitalization or nonhospitalization of a patient has no direct bearing on the coverage or exclusion of a given dental procedure. (See also §§ 210.7 and 245 for additional information on dental services.)

260.13 Items and services to the extent that payment has been made, or can reasonably be expected to be made **under a workmen's compensation law** or plan of the United States or a State may not be paid for

by the program. Payments for items and services under the health insurance program are subject to repayment to the appropriate trust fund if notice or information is received that payment has been made for the items and services under a workmen's compensation plan. (See § § 289 ff.)

260.14 Items or services which the provider is obligated by a law of or because of a contract with the Federal Government to **render at public expense** are not covered. This exclusion applies to services furnished to veterans pursuant to a contract with the Veterans Administration.

260.15 Items and services are not covered when furnished by a Federal provider of services or other Federal agency except (a) for emergency inpatient hospital services and emergency outpatient hospital diagnosis services furnished by a Federal hospital meeting the requirements of § 202, or (b) when the Federal provider of services is determined by the Secretary of Health, Education, and Welfare to be providing services to the public generally as a community institution or agency.

261 CUSTODIAL CARE

As indicated in § 260.9, custodial care is excluded from coverage under medicare.

261.1 Custodial Care in General Hospitals.

A. Definition.—Custodial care is care designed essentially to assist an individual to meet his activities of daily living—i.e., services which constitute personal care such as help in walking and getting in and out of bed, assistance in bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication which can usually be self-administered—and which does not entail or require the continuing attention of trained medical or paramedical personnel.

Two basic facts must be noted in connection with this definition. **First**, the definition of custodial care does not contemplate an intermediary level of care between covered and custodial care. Accordingly, a decision that an individual is not receiving custodial care is also a decision that the care provided is covered. **Second**, a decision that an individual lacks rehabilitation potential would not necessarily mean that the care furnished him is custodial care. Many patients who have no potential for rehabilitation require a level of care which is covered under the

program. **For example**, a terminal cancer patient whose life expectancy is not more than a few months who requires palliative treatment, periodic "tapping" to relieve fluid accumulation, and careful skin care and hygiene to minimize discomfort is not receiving custodial care. Thus, the controlling factor in determining whether a person is receiving custodial care is the level of care and medical supervision that the patient requires, rather than considerations such as diagnosis, type of condition, or degree of functional limitation.

B. Criteria for Applying Definition of Custodial Care.—Generally, the care furnished an individual requires the continuing attention of trained medical or paramedical personnel if: **First**, the individual's condition medically warrants **skilled services**, and, **Second**, the need for such services constitutes the **primary purpose of the total care** furnished the individual.

1. Skilled Services.—A skilled service is one which **must** be furnished by or under the supervision of trained medical or paramedical personnel to assure the safety of the patient and achieve the medically desired result. A service is not classified as skilled merely because it is performed by a trained medical or paramedical person. A service which can be safely and adequately self-administered or performed by the average, rational, nonmedical person, without the direct supervision of trained medical or paramedical personnel, is a nonskilled service without regard to who actually provides the service. **For example**, a patient, following instructions, can normally take oral medicine. Consequently, giving of oral medicine by a nurse to a patient who is unable to take it himself because of senility would not change the service from a nonskilled to a skilled service.

2. Primary Purpose of Care Furnished.—If the primary purpose of the total care provided an individual is to assist him in meeting the activities of daily living, the custodial care exclusion applies and no payment can be made under the program for any of the care furnished him. However, if the skilled services furnished the patient are the primary purpose for the total care provided, the custodial care exclusion does not apply and payment may be made for services covered under the program.

Where continuing professional nursing services are not necessary, the provision of skilled services to hospital inpatients by other paramedical personnel would not ordinarily justify a finding that such paramedical

services are the primary purpose for the total care furnished a patient. Thus, the determination of whether the primary purpose of the total care furnished is to assist the patient to meet the activities of daily living, or the provision of skilled services, will generally depend on whether the individual's condition requires that the services of a nurse be available to him at all times.

If it is medically necessary to have the services of a nurse available to the patient at all times, the need for this service alone establishes that the primary purpose of the total care is the provision of this skilled service. **For example**, pending stabilization of his condition, the only skilled service a patient with arteriosclerotic heart disease may require is continuing close observation by a trained nurse for signs of decompensation, loss of fluid balance, and the need for adjustment in digitalis dosage. However, since the immediate institution of necessary medical procedures could make the difference between life and death when decompensation is indicated, such observation by trained personnel is absolutely essential to the individual's well-being. The primary purpose of the total care provided this patient is furnishing this skilled service, therefore, the custodial care exclusion does not apply.

When a patient does not require nursing services, the primary purpose of the total care furnished is generally to assist him in meeting his activities of daily living.

Where the need for nursing services is only minimal, the furnishing of skilled services is the primary purpose of the total care furnished only if the range and intensity of all the skilled services furnished in view of the patient's condition, are such that they could not be performed outside the institutional setting. These situations will probably be limited to those where an individual is hospitalized for the running of extensive diagnostic tests.

3. Significance of Physicians' Services.—All physician services rendered to a patient are skilled services. However, even though in an institutional setting the services of a physician may be readily available, generally the physician visits a patient only periodically. He delegates to the nurse the responsibility for keeping, where necessary, close watch for changes in the patient's condition requiring immediate medical action.

Many individuals who require only custodial care may need periodic physician visits for assessment of

their medical status so a medical decision may be made as to whether changes are required in the type of care they are receiving. Nevertheless, periodic visits by a physician to a patient do not change the custodial character of the care when the primary purpose of the total care furnished the patient by the hospital is to assist him to meet his activities of daily living.

(Periodic visits by a physician to his patient are covered under Part B if reasonable and necessary to the treatment of the patient's illness or injury. Such physician services are reimbursable even though a finding has been made that the care furnished the patient in the hospital is custodial and therefore not covered.)

C. Examples of Custodial Care in General Hospitals.—

1. A stroke patient who is ambulatory, has no bladder or bowel involvement, no serious associated or secondary illnesses and does not require medical or paramedical care but requires only the assistance of an aide in feeding, dressing, and bathing.

2. The cardiac patient who is stable and compensated and has reasonable cardiac reserve and no associated illnesses, but who, because of advanced age, has difficulty in managing alone in his home, and requires assistance in meeting the activities of daily living.

3. The senile patient who has diabetes which remains stabilized as long as someone sees to it that he takes his oral medication, and sticks to a prescribed diet.

261.2 Custodial Care in Psychiatric Hospitals.

—The basic principle underlying the provisions for the coverage of inpatient psychiatric hospital services is that payment is to be made by the program only for "active treatment" which can reasonably be expected to improve the patient's condition. To provide assurance that payment is made only under such circumstances, and to preclude the possibility of payment being made for care that is essentially custodial in nature, the law includes certain requirements which must be met before the services furnished in a psychiatric hospital can be covered.

First, the certification that a physician must provide with respect to inpatient psychiatric hospital services is required to include a statement that the

services furnished can reasonably be expected to improve the patient's condition. **Second**, the law provides that payment may be made for these services only if they were being furnished while the patient was receiving either active treatment or admission and related services necessary for diagnostic study. (Thus, the period of time during which an individual receives inpatient psychiatric hospital services which meet the above requirements is, for purposes of the medicare program, considered a **period of active treatment**. Conversely, a patient in a psychiatric hospital who receives services which do not meet the above requirements is, during the period he is receiving such services, considered to be receiving custodial care.) Finally, of course, the law includes a specific exclusion of custodial care which is generally applicable to all kinds of provider services.

Before setting forth the guidelines to be followed in making determinations as to whether the care furnished an individual constitutes active treatment or custodial care, it must be noted that in the context of inpatient psychiatric hospital services emphasis is placed on the presence of "active treatment" and that, therefore, this determination is the crucial one. Simply applying the custodial care definition for general hospitals (§ 261.1A.) would not be sufficient for purposes of determining whether payment may be made since the custodial care definition does not take into account the patient's potential for improvement nor was it designed to permit the more sophisticated judgments required by the concept of active treatment. Consequently, the concept to be applied in rendering determinations with respect to inpatient psychiatric hospital services is the definition of active treatment.

A. Definition of Active Treatment.—The term "active treatment" is defined in a manner designed to reflect and implement the physician certification requirement described above. For services in a psychiatric hospital to be designated as "active treatment," they must be: (a) provided under an individualized treatment or diagnostic plan, (b) reasonably expected to improve the patient's condition or for the purpose of diagnosis, and (c) supervised and evaluated by a physician. Such factors as diagnosis, length of hospitalization, and the degree of functional limitation, while useful as general indicators of the kind of care most likely being furnished in a given situation, are not controlling in deciding whether the care was active treatment. The following is a discussion of each element of the above definition of active treatment:

1. Individualized Treatment or Diagnostic Plan.—The services must be provided in accordance with an individualized program of treatment or diagnosis developed by a physician in conjunction with staff members of appropriate other disciplines on the basis of a thorough evaluation of the patient's restorative needs and potentialities. Thus, an isolated service, e.g., a single session with a psychiatrist, or a routine laboratory test not furnished under a planned program of therapy or diagnosis would not constitute active treatment, even though the service was therapeutic or diagnostic in nature. The plan of treatment must be recorded in the patient's medical record in accordance with section 405.1037(a)(8) of the regulations on Conditions of Participation for Hospitals.

2. Services Expected to Improve the Condition or for Purpose of Diagnosis.—The services must reasonably be expected to improve the patient's condition or must be for the purpose of diagnostic study. It is not necessary that a course of therapy have as its goal the restoration of the patient to a level which would permit discharge from the institution although the treatment must, at a minimum, be designed both to reduce or control the patient's psychotic or neurotic symptoms which necessitated hospitalization and improve the patient's level of functioning.

The kinds of services which meet the above requirements would include not only psychotherapy, drug therapy, and shock therapy, but also such adjunctive therapies as occupational therapy, recreational therapy, and milieu therapy, provided the adjunctive therapeutic services are expected to result in improvement (as defined above) in the patient's condition. If, however, the only activities prescribed for the patient are primarily diversional in nature, i.e., to provide some social or recreational outlet for the patient, it would not be regarded as treatment to improve the patient's condition. In many large hospitals these adjunctive services are present and part of the life experience of every patient. In a case where milieu therapy (or one of the other adjunctive therapies) is involved, it is particularly important that this therapy be a planned program for the particular patient and not one where life in the hospital is designated as milieu therapy.

In accordance with the above definition of "improvement," the administration of antidepressant or tranquilizing drugs which are expected to significantly alleviate a patient's psychotic or neurotic symptoms would be termed active treatment (assuming that the other elements of the definition are met). However,

the administration of a drug or drugs does not of itself necessarily constitute active treatment. Thus, the use of mild tranquilizers or sedatives **solely** for the purpose of relieving anxiety or insomnia would not constitute active treatment.

3. Services Supervised and Evaluated by a Physician.—Physician participation in the services is an essential ingredient of active treatment. The services of qualified individuals other than physicians, e.g., social workers, occupational therapists, group therapists, attendants, etc., must be prescribed and directed by a physician to meet the specific psychiatric needs of the individual. In short, the physician must serve as a source of information and guidance for all members of the therapeutic team who work directly with the patient in various roles. It is the responsibility of the physician to periodically evaluate the therapeutic program and determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed. Such evaluation should be made on the basis of periodic consultations and conferences with therapists, reviews of the patient's medical record, and regularly scheduled patient interviews—at least once a week.

Although in an institutional setting the services of a physician may be readily available, the general pattern is for the physician to visit the patient only periodically, delegating to nursing personnel the responsibility for intensive observation of patients, where it is necessary. Such periodic visits to a patient do not in themselves constitute active treatment. Conversely, when the physician periodically evaluates the therapeutic program to determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed based on consultations and conferences with therapists, review of the patient's progress as recorded on his medical record and his periodic conversations with the patient, active treatment would be indicated. The treatment furnished the patient should be documented in the medical record in such a manner and with such frequency as to provide a full picture of the therapy administered as well as an assessment of the patient's reaction to it. (See section 405.1037(a)(9) and (10) of the regulations on Conditions of Participation for Hospitals.)

A finding that a patient is not receiving active treatment will not in itself preclude payment for physicians' services under Part B. As long as the professional services rendered by the physician are reasonable and necessary for the care of the patient,

such services would be reimbursable under the medical insurance program.

B. Principles for Evaluating a Period of Active Treatment.—As indicated, the period of time covered by the physician's certification is referred to as a "period of active treatment." This period should include all days on which inpatient psychiatric hospital services were provided because of the individual's need for active treatment—not just the days on which specific therapeutic or diagnostic services were rendered. For example, a patient's program of treatment may necessitate the discontinuance of therapy for a period of time or it may include a period of observation, either in preparation for, or as a followup to therapy, while only maintenance or protective services are furnished. If such periods were essential to the overall treatment plan, they would be regarded as part of the period of active treatment.

The fact that a patient is under the supervision of a physician does not necessarily mean that he is getting active treatment. For example, medical supervision of a patient may be necessary to assure the early detection of significant changes in his condition; however, in the absence of a specific program of therapy designed to effect improvement, a finding that the patient is receiving active treatment would be precluded.

The program's definition of active treatment does not automatically exclude from coverage services rendered to patients who have conditions which ordinarily result in progressive physical and/or mental deterioration. Although patients with such diagnoses will most commonly be receiving custodial care, they may also receive services which meet the program's definition of active treatment. This might be the case, for example where a patient with Alzheimer's or Pick's disease received services designed to alleviate the effects of paralysis, epileptic seizures, or some other neurological symptom, or where a patient in the terminal stages of any disease, received life-supportive care. A period of hospitalization during which services of this kind were furnished would be regarded as a period of active treatment.

C. Documentation Needed for Conditions which Generally Require Custodial Care Only.—In order to expedite the processing of hospital bills and to eliminate the necessity for the intermediary to recontact the hospital for additional information when the diagnosis consists of a condition which ordinarily

results in progressive physical and/or mental deterioration, the hospital bill in such cases must be accompanied by a supplementary explanatory statement. This statement should describe: (a) the specific therapeutic or diagnostic services rendered during the period covered by the bill; (b) the role of the physician in administering such services; and (c) the plan of treatment (or diagnosis) under which the services were rendered. Such a supplementary statement will be required wherever the diagnosis consists of any progressive disabling disease for which custodial services are generally furnished. (In lieu of the statement, a clear photocopy of the patient's medical record and a plan of treatment may be submitted.) This includes the **chronic brain disorders and mental deficiencies** listed under code numbers 10–19 and 60–62 (new nomenclature) of the American Psychiatric Association's *Diagnostic and Statistical Manual, Mental Disorders*. In addition, a supplementary statement showing why hospitalization was necessary for treating the patient should be submitted wherever the diagnosis consists of a psychoneurotic disorder listed under code number 40 in the above manual.

1. Nature of the Diagnosis.—Supplementary information should be submitted routinely wherever the diagnosis recorded on the billing form consists of any progressive disabling disease for which custodial services are generally furnished.

Example: Hospital bill indicates diagnosis of chronic brain syndrome association with trauma. Hospital statement reports that medical record indicates that as a result of a fight in which patient received severe blows to the head, patient suffered brain damage resulting in deterioration of his mental processes and epilepsy. The services for which billing is made include diagnostic evaluation and determining proper treatment for the control of the epilepsy. The plan of treatment indicates that patient will probably receive active treatment for period of 40 to 50 days. Statement is satisfactory, physician's role is implied by reference to plan and result of diagnostic study.

2. The Patient's Prior Hospitalization Record.—The hospital should submit supplementary information whenever the patient's prior hospitalization record, either alone or in combination with other factors, suggests that a period of hospitalization may not have constituted active treatment. For example, where the billing form shows that an individual had been a patient of a psychiatric hospital for a considerable

time, e.g., 60 days or more, before his first day of entitlement, and was admitted to active care shortly after such first day, there would be sufficient basis for submitting supplementary information concerning the stay.

Example: Hospital bill indicates that patient was admitted to active care the second day after he became entitled to hospital benefits. It also indicated that he had been a patient of that same institution for 62 days before being admitted to active care. The provider stated that the patient's medical record indicates that the patient failed to respond to somatic treatment including antidepressants and management of his general physical condition when first admitted to the hospital. A psychiatrist, specializing in work with geriatric patients, was employed by the hospital shortly before this patient became entitled to hospital benefits. The psychiatrist undertook group therapy and an active program designed to involve the patient's family in his care. This therapy is to continue for a period of at least 2 months and may continue for many more. Supplementary information is sufficient to establish provision of active treatment.

3. Ancillary Services Furnished.—Where a hospital itemized ancillary services separately on its bill, the nature and amount of such services would be an important factor to consider in deciding whether the patient was receiving active care. For example, where no ancillary services are listed by a hospital which ordinarily itemizes such services, the hospital should furnish supplementary information showing that active treatment was furnished. On the other hand, the fact that extensive ancillary services are listed would not in itself demonstrate that the services constituted active treatment. The hospital should routinely furnish supplementary information when the bill would not in itself contain sufficient explanation for the intermediary to determine whether active care was furnished.

Example: Hospital bill submitted for patient with schizophrenia, catatonic withdrawal type, indicates patient has been receiving occupational therapy. The last day of active treatment furnished to this patient was 3 weeks before this bill. Since the patient's return to active treatment, particularly to occupational therapy, would raise questions, the hospital submitted supplementary information. The hospital's statement indicated that the patient's medical record showed a resurgence in a youthful interest in music; patient's family purchased a harp for patient which he was re-

learning to play. The return of interest in music made the patient more accessible to individual psychotherapy and to other activity therapies. The plan for this treatment indicated that therapy would be given for a period of 60 days. However, physician's last entry in medical record indicated patient's progress so rapid, he would probably be discharged before 60 days expired. Supplementary statement is sufficient to establish that patient was receiving active treatment.

4. Documentation When Hospital Furnishes Only Intensive Services.—Although an intermediary would be less likely to question the bill of an institution known to furnish only intensive services and which has no custodial patients, than that of a hospital which provides both intensive treatment and custodial care, a supplementary statement should always be furnished where the diagnosis is one which fits any of the disease categories referred to above.

Requirements for Payment

270. REQUEST FOR PAYMENT

Before payment can be made for an inpatient hospital stay, outpatient hospital diagnostic study, hospital services under medical insurance, or physicians' services billed through the hospital, a written request for payment signed by the patient, or by another person qualified to do so on his behalf must be filed. The signature of the patient or other qualified person may be obtained on the respective billing forms, or, under specified conditions, the hospital may obtain a single signature on its records.

If a fully competent and capable patient **refuses** to sign the request for payment necessary for the hospital to obtain reimbursement for the services it furnished, the hospital may charge the patient or other person for the covered services.

270.1 Billing Forms as Request for Payment.—Each of the billing forms (Inpatient Hospital Admission and Billing, Form SSA-1453; Inpatient Psychiatric or Tuberculosis Hospital Admission and Billing, Form SSA-1485; Outpatient Hospital Billing, Form SSA-1483; and Provider Billing for Patient Services by Physicians, Form SSA-1554) contains a patient's signature line incorporating the patient's request for payment of benefits, authorization to release information and assignment of benefits. When the billing form is used as the request for payment, the billing form must be signed. The request for payment will then be forwarded to the intermediary or, to the Social

Security Administration where the hospital deals directly with the Government, when the hospital submits its bill.

A. The billing form as request for payment will be signed in connection **with each inpatient hospital admission**, even though multiple admissions may occur during the same spell of illness. Only one request for payment has to be signed, however, in connection with each inpatient admission, even though an extended hospital stay occasions multiple billings.

B. Where the billing form is used as the request for payment for **physicians' services billed through the hospital for outpatient diagnostic studies and for other outpatient hospital services**, a signature is required with each billing by the hospital.

270.2 Request for Payment on Hospital Record.—In lieu of separate signatures on the billing forms, the hospital may arrange with its hospital insurance intermediary to have the patient's signature on its admission records serve as the request for payment.

The pertinent language on the billing forms must be incorporated, by printing or stamp, either in the hospital's own admission forms, or on a separate form attached to or associated with the hospital's admission form. Where this procedure is adopted, "Patient's request for payment on file" should be stamped on the patient's signature line of the original of the billing form to indicate that the patient's statement is on file.

When the hospital has arranged with its hospital insurance intermediary to put this procedure into effect, the intermediary will make payment to the hospital without the patient's signature on the billing form. The Part A intermediary will verify through its regular audit activities that the signatures are being obtained as specified. The medical insurance carrier will rely on the Part A intermediary's administration of this procedure and will make payment to a hospital without the patient's signature on the form SSA-1554.

The following format is suggested for the statement on the hospital's record:

"Statement to Permit Payment of Hospital and Medical Insurance Benefits to Hospital

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made in my behalf.

I assign payment for the unpaid charges of the physician(s) for whom the hospital is authorized to bill in connection with its services. I understand I am responsible for any health insurance deductibles and 20 percent of the remaining reasonable charges.

For outpatient services, I request that this authorization apply to the period _____ to _____."

Where the hospital does not bill on behalf of its hospital-based physicians, the assignment part of the above statement should be omitted. Where a patient does not want to assign the benefits for services of a hospital-based physician, the assignment language should be lined out in that particular case.

A. For inpatient billing, the patient's signature will cover only that particular stay regardless of its duration. When the patient is admitted for a new inpatient stay, another request for benefits is required.

B. For outpatient billing, the designated period of time to be entered in the statement on the hospital record should be appropriate to the circumstances. Where there is an outpatient hospital admission with repeated visits expected, a period deemed to correspond with the anticipated period of treatment may be entered but not to exceed 1 year. Some hospitals may prefer to restrict the period to accommodate their own admission or billing requirements.

C. When hospital-based physician services are billed under this procedure, the effective period of the patient's signature will be the same as that for the re-

lated inpatient or outpatient billing. Thus, the patient's signature will cover all Form SSA-1554's filed in connection with a single inpatient stay, or for services in the designated outpatient billing period.

271. EXECUTION OF THE REQUEST FOR PAYMENT

If at all practicable, the patient should sign the request either on the billing form or on the hospital's record at the time of admission. (See Admission Procedures, §§ 300 ff.)

In certain circumstances, it would be impracticable for an individual to sign the request for payment himself because when he is admitted to the hospital, or begins outpatient hospital diagnostic or other hospital services, he is unconscious, incompetent, in great pain, or otherwise in such a condition that he should not be asked to transact any business. In this situation, his representative payee (i.e., a person designated by the Social Security Administration to receive monthly benefits on the patient's behalf), a relative, legal guardian, or a representative of an institution (other than the hospital) usually responsible for his care, or a representative of a governmental entity providing welfare assistance should, if present at time of admission, be asked and permitted to sign on his behalf.

When no request for payment is obtained at the time of admission, the hospital should attempt to obtain such a request later from the patient or other person described above. If the request cannot be so obtained by the time the hospital would ordinarily submit its bill to the intermediary, an authorized official of the hospital may sign the request.

When someone other than the patient signs the request for payment, have the signer briefly state his relationship to the patient and the circumstances which made it impracticable for the patient to sign. The hospital will forward this statement on or with its billing, or retain it in its files if the signature is obtained on its own record. The intermediary will generally accept such a statement as true in the absence of evidence to the contrary.

In some cases of outpatient diagnostic services, whether furnished under Part A or Part B, the hospital need not attempt to obtain the patient's signature. This is the situation in which the physician sends a specimen (e.g., blood or urine sample) to a laboratory of a participating hospital for analysis. The patient himself does not go to the hospital, but the tests are billed through it. The hospital may sign on behalf of the patient and should note in the space provided

for the patient's signature on the Outpatient Hospital Billing (SSA-1483) and any accompanying Provider Billing for Patient Services by Physicians (SSA-1554), "Patient not physically present for tests." This does not apply when the patient actually goes to the hospital for tests and the hospital fails to obtain his signature while he is there.

Except in the outpatient case where the patient is not physically present, the hospital should not routinely sign the request on behalf of any patient. If experience reveals an unusual frequency of such hospital signed requests from a particular hospital, the matter will be subject to review by the intermediary.

Certification and Recertification by Physicians

273. CERTIFICATION AND RECERTIFICATION BY PHYSICIANS—GENERAL

Payment may be made for covered hospital services only if a physician certifies to the medical necessity for the services. For services continued over a period of time, a physician must recertify the continued need for the services at specified intervals. Appropriate supporting material may be required.

Hospitals will not transmit physician certification and recertification statements to the intermediary, or to the Social Security Administration if the hospital deals directly. The hospital must itself certify, on the appropriate billing form, that the required physician certification and recertification statements have been obtained and are on file. The physician certification and recertification statements will be retained in the hospital's files where they will be available for verification if needed.

A hospital must also have available in its files a description of the procedure it adopts on the timing of recertifications—that is, the intervals at which recertifications will be required and whether review of long-stay cases by the utilization review committee will serve as an alternative to recertification by a physician in the case of the third or subsequent recertifications.

273.1 Failure to Certify or Recertify.—If a hospital fails to obtain the required certification and recertification statements in an individual case, program payment cannot be made in that case.

If the hospital's failure to obtain a certification or recertification is not due to a question as to the necessity for the services, but rather to the physician's

refusal to certify based on other grounds (e.g., he objects in principle to the concept of certification and recertification), the hospital may not charge the beneficiary for any covered items or services furnished him. The provider agreement which the hospital files with the Secretary precludes it from doing so.

If a physician refuses to certify because, in his opinion, hospitalization was not required for medical treatment or diagnostic study, the services are not covered and the hospital can bill the patient directly. The reason for the physician's refusal to make the certification must be documented in the hospital records.

274. INPATIENT HOSPITAL SERVICES CERTIFICATION

The inpatient hospital services certification should state the medical necessity for inpatient hospital admission. It is not necessary to state the reason(s) why hospital admission is necessary.

The certification of the medical necessity for inpatient hospital services must be signed by the admitting physician or a medical staff member with knowledge of the case. The routine admission procedure followed by a physician would not ordinarily of itself be sufficient certification of the medical necessity for hospitalization for purposes of the program.

When a patient is hospitalized for a **covered** dental procedure (see §§ 210.7 and 260.12), the dentist is a "physician" (§ 245) and may certify and recertify to the medical necessity for inpatient hospital services. If a patient must be hospitalized for a **noncovered** dental procedure because he has a nondental impairment, e.g., a heart condition, the physician responsible for the treatment or management of the nondental impairment must certify to the necessity for the patient's hospitalization for the impairment.

Certifications must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable. However, the individual hospital determines the method by which certifications are to be obtained and the format of the certification statement. Thus, the medical and administrative staffs of each hospital may adopt the procedure they find most convenient and appropriate.

There is no requirement that the certification be entered on any specific form or handled in any specific way, as long as the approach adopted by the hospital permits the intermediary (or the Social Security Administration where the hospital deals directly with the Government) to de-

termine that the certification requirement is in fact met. The certification could, therefore, be entered or preprinted on a form the physician already has to sign; or a separate certification form could be used.

275. RECERTIFICATION FOR INPATIENT HOSPITAL SERVICES

The recertification statement must meet the following standards: it must contain an adequate written record of the reasons for continued hospitalization, the estimated period of time the patient will need to remain in the hospital, and plans for posthospital care. The recertification statement made by the physician has to meet the content standards unless, for example, all of the required information is included in progress notes, in which case the physician's statement could indicate that the individual's medical record contains the information required by the standards and that continued hospitalization is medically necessary.

A physician who recertifies to the need for continued inpatient stay should use the same criteria that apply to the hospital's utilization review committee. Where the basis for the recertification is the need for continued inpatient care because of the lack of extended care facility accommodations (§ 290.3), the recertification should so state. The physician should attempt on a continuing basis to place his patient in a participating extended care facility as soon as a bed becomes available.

Recertifications are to be signed by the attending physician or a medical staff member with knowledge of the case. The hospital determines the form of the written record and the manner of obtaining timely recertifications. Thus, the hospital is able to adopt a procedure for obtaining timely recertifications that suits it best.

Where the requirements for the third or a subsequent recertification are satisfied by review of a stay of extended duration, pursuant to the hospital's utilization review plan, a separate recertification statement is not required. However, it is necessary to satisfy the recertification content standards. It would be sufficient if records of the utilization review committee show that consideration was given to the three items mentioned above—the reasons for continued hospitalization, estimated time the patient will need to remain in the hospital, and plans for posthospital care.

276. TIMING OF RECERTIFICATIONS

The first recertification is required no later than as of the 14th day of hospitalization. A hospital may,

at its option, provide for the first recertification to be made earlier, or it may vary the timing of the first recertification within the 14-day period by diagnostic or clinical categories.

A second recertification is required no later than as of the 21st day of hospitalization. Thereafter, subsequent recertifications must be made at intervals established by the utilization review committee (on a case-by-case basis if it so chooses), but in no event may the prescribed interval between recertifications exceed 30 days. The utilization review committee will be reviewing long-stay cases and may be in the best position to decide when subsequent recertifications are needed.

A hospital can, if it wishes, coordinate its physician certifications with the process of review by the utilization review committee of long-stay cases. At the option of a hospital, review of a stay of extended duration under the hospital's utilization review plan may take the place of the third and any subsequent physician recertifications. (Such review may be the initial review, or a second or subsequent review of an extended-stay case by the utilization review committee.)

Where review of an extended-stay case by the utilization review committee is deemed to take the place of a physician recertification, it would be possible for the recertification to be made later than the specified day, because the review of an extended duration case may be made at any time within the 7-day period following the last day of the period of extended duration defined in the utilization review plan. Such a recertification will be treated as a delayed recertification, however, no explanation for the normal delay is required.

277. INPATIENT PSYCHIATRIC HOSPITAL SERVICES CERTIFICATION AND RECERTIFICATION

The requirements for physician certification and recertification for inpatient psychiatric hospital services are generally the same as for inpatient hospital services. However, the required content of the certification and recertification statements differs from the content of the statements required for inpatient hospital services.

The certification should state that the inpatient psychiatric hospital admission was medically necessary, for either (1) treatment which could reasonably be expected to improve the patient's condition, or (2) diagnostic study.

The recertification should state (1) that inpatient psychiatric hospital services furnished since the previous certification or recertification were, and continue to be, medically necessary for either (a) treatment which could reasonably be expected to improve the patient's

condition, or (b) diagnostic study; and (2) that the hospital records indicate that the services furnished were either intensive treatment services, admission and related services necessary for diagnostic study, or equivalent services.

For convenience, the period covered by the physician's certification and recertification is referred to as a period during which the patient was receiving **active treatment**. If the patient remains in the hospital but the period of "active treatment" ends (e.g., because the treatment cannot reasonably be expected to improve the patient's condition, or because intensive treatment services are not being furnished), program payment can no longer be made even though the patient has not yet exhausted his benefits. Where the period of "active treatment" ends, the physician is to indicate the ending date in making his recertification. If "active treatment" thereafter resumes, the physician should indicate, in making his recertification, the date on which it resumed.

278. INPATIENT TUBERCULOSIS HOSPITAL SERVICES CERTIFICATION AND RE-CERTIFICATION

The requirements for physician certification and recertification for inpatient tuberculosis hospital services are generally the same as for inpatient hospital services. However, the required content of the certification and recertification statements differs from the content of the statements required for inpatient hospital services.

The **certification** should state that the inpatient tuberculosis hospital admission was medically necessary for treatment which could reasonably be expected either to (1) improve the patient's condition, or (2) render the condition noncommunicable.

The **recertification** should state (1) that the inpatient tuberculosis hospital services furnished since the previous certification or recertification were, and continue to be, medically necessary for treatment which could reasonably be expected either to (a) improve the patient's condition, or (b) render the condition noncommunicable; and (2) that the hospital records indicate such medical necessity.

For convenience, the period covered by the physician's certification and recertification is referred to as a period during which the patient was receiving **active treatment**. If the patient remains in the hospital but the period of "active treatment" ends (e.g., because the treatment cannot reasonably be expected to improve the patient's condition), program payment can no longer be made even though the patient has not yet exhausted

his benefits. Where the period of "active treatment" ends, the physician is to indicate the ending date in making his recertification. If "active treatment" thereafter resumes, the physician should indicate, in making his recertification, the date on which it resumed.

279. OUTPATIENT HOSPITAL DIAGNOSTIC SERVICES CERTIFICATION

A physician should state that outpatient hospital diagnostic services are required for a diagnostic study.

Certification as to outpatient diagnostic services may be made on the physician's orders, on the copy of the summary prepared at the conclusion of the study that is retained by the hospital, or a special form may be used.

Recertification is not required for outpatient hospital diagnostic services. However, if the diagnostic service extends beyond 20 days, a new certification is required for each study period.

280. CERTIFICATION FOR HOSPITAL SERVICES COVERED BY THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

A physician must certify that the medical and other health services covered by medical insurance which were provided by (or under arrangements made by) the hospital were medically required.

When the hospital provides ambulance service to transport the patient from the scene of an accident and no physician is involved until the patient reaches the hospital, any physician in the hospital who examines the patient or has knowledge of the case may certify to the medical need for the ambulance service.

This certification requires a brief description of the services and the signature of the physician. It need be made only once for a course of treatment. Where services are provided on a continuing basis, such as a course of radium treatments, the physician's certification may be made at the beginning or end of the course of treatment, or at any other time during the period of treatment.

There is no requirement that the certification be entered on any specific form or handled in any specific way, as long as the approach adopted by the hospital permits the intermediary (or the Social Security Administration where the hospital deals directly with the Government) to determine that the certification requirement is in fact met. The certification could, therefore, be entered or preprinted on a form the physician already has to sign; or a separate certification form could be used.

281. DELAYED CERTIFICATIONS AND RECERTIFICATIONS

Hospitals are expected to obtain timely certification and recertification statements. However, delayed certifications and recertifications will be honored where, for example, there has been an oversight or lapse.

In addition to complying with the appropriate content requirements, delayed certifications and recertifications must include an explanation for the delay and any medical or other evidence which the hospital considers relevant for purposes of explaining the delay. The hospital will determine the format of delay certification and recertification statements, and the method by which they are obtained. A delayed certification and recertification may appear in one statement; separate signed statements for each certification and recertification are not required as they would be if timely certification and recertification had been made.

282. TIMING OF CERTIFICATION AND RECERTIFICATION FOR BENEFICIARY ADMITTED BEFORE ENTITLEMENT

If an individual is admitted to a hospital (including a psychiatric or tuberculosis hospital) before he is entitled to hospital insurance benefits (for example, before he reaches age 65), the following rules apply when he does become entitled.

No certification as to the medical necessity for inpatient admission is required. Recertifications are required as of the time they would be required if the patient had been admitted to the hospital on the day he became entitled. For example, if a patient becomes entitled to Part A benefits on May 1, but was admitted prior to that date, the first recertification is required no later than May 14; the second recertification is required no later than May 21; subsequent recertifications are required at intervals not to exceed 30 days.

Psychiatric and Tuberculosis Hospital Records

283. PSYCHIATRIC AND TUBERCULOSIS HOSPITAL RECORDS

The law requires that psychiatric and tuberculosis hospital records contain certain specific information concerning the individual patient's condition and the nature of the treatment provided.

283.1 In the case of **inpatient psychiatric hospital services** the hospital records must show that the services were furnished to the patient during periods

when he was receiving intensive treatment services, admission and related services necessary for a diagnostic study, or equivalent services. As noted in § 277, the physician recertification for inpatient psychiatric hospital services must include a statement that the hospital records so indicate.

283.2 In the case of **inpatient tuberculosis hospital services** the hospital records must show that the services were furnished to the patient during periods when he was receiving treatment (including diagnostic services) which could reasonably be expected to improve his condition or render it noncommunicable. As noted in § 278, the physician recertification for inpatient tuberculosis hospital services must include a statement that the hospital records so indicate.

Special Provisions Related to Payment

285. REFUNDS

In its participation agreement, the hospital agrees not to charge for items or services for which an individual is entitled to have payment made on his behalf, and to make adequate provision for return (or other disposition) of any money incorrectly collected from an individual or from any other person on his behalf (e.g., other insurance carriers or welfare).

Money incorrectly collected means amounts in excess of the deductible or coinsurance, paid to a hospital by or on behalf of an individual for covered items and services for which he is entitled to have payment made under the health insurance program.

Incorrect collections may result from billing a beneficiary in error for a covered item or service; or from retroactive entitlement; or workmen's compensation cases in which the beneficiary has paid for covered services to which he later becomes entitled under health insurance. A claim for payment under the guarantee of payment provision (§ 286) may also involve sums incorrectly collected.

Where the intermediary knows that a hospital has overcollected deductible and coinsurance amounts for outpatient hospital services, it will make direct refund to the beneficiary. (See § 420.)

285.1 Return or Other Disposition of Money Incorrectly Collected.—A hospital that has incorrectly collected is required to refund or set aside the money. Until the hospital refunds or sets aside the money incorrectly collected, an equivalent amount may be withheld from payments otherwise due the hospital.

A. Making Refund.—Refund is to be made to the beneficiary, or any other person from whom the hospital collected the money. If the proper person cannot be located after reasonable effort (including an attempt at contact by mail at the last known address), the hospital should request the intermediary to have the Social Security Administration's records examined for the individual's address. If the individual still cannot be located, or he is dead, the hospital is to dispose of the money in accordance with the law of the State in which it is located.

B. Money Set Aside.—Where the individual's whereabouts are unknown, there is a delay in the appointment of a legal representative of the estate of a deceased individual, and other cases in which refund may be delayed indefinitely, the hospital will notify the intermediary and will set the funds aside in a separate account identified by the name of the individual to whom the payment is due. These accounts will be carried on the hospital's records in this manner until final disposition is made under the applicable State law.

C. Time Limits Within Which Hospital Action Must Be Taken.—The incorrect collection should be refunded as promptly as possible. If refund cannot be made within 60 days after the date of the notice to the hospital that an incorrect collection was made, the funds must be set aside as described in B above.

286. GUARANTEE OF PAYMENT PROVISIONS

A hospital may be paid, under certain conditions, for inpatient hospital services furnished to a beneficiary whose eligibility for inpatient hospital benefit days in a spell of illness has been exhausted. The guarantee also extends to inpatient psychiatric hospital services furnished to an individual who has used up his 190-day lifetime limitation on such services. (The guarantee extends **only** to inpatient services furnished to individuals who have exhausted their eligibility for inpatient services. It does not extend to individuals who have no coverage for other reasons, e.g., one who is not entitled under the hospital insurance program, or whose entitlement has been terminated.) The provision assures at the time of admission that payment will be made to a hospital for its services during the time it takes to notify the hospital of the patient's utilization record.

The guarantee includes not only cases in which inpatient benefits were already exhausted prior to ad-

mission, but cases where a beneficiary had some inpatient hospital benefits remaining at the time of his admittance to a hospital, e.g., 2 or 3 days of remaining eligibility, but these benefits are exhausted before the intermediary's reply to the Notice of Admission reaches the hospital. Payment under the guarantee, i.e., for those days after benefits are exhausted, is made at the full rate. The coinsurance provision does not apply.

The guarantee applies only to inpatient hospital services. It does not apply to other benefits provided under the hospital or medical insurance programs. A hospital is not required to claim payments under this provision; it may look to the patient for payment.

286.1 Requirements for Payment Under the Guarantee.—The following conditions must be met for a hospital to receive payments under this provision. The hospital should submit an explanation of the circumstances with its bill.

A. The services provided by the hospital are covered inpatient hospital services.

B. The hospital acted in good faith in assuming that the individual was entitled to inpatient hospital benefits. If it is found that the hospital acted reasonably, in accordance with C below, it will generally be presumed to have acted in good faith. There would be an absence of good faith if the hospital had, or should have had, a substantial doubt that coverage existed.

C. There were reasonable grounds for the hospital to assume that entitlement to benefits existed. The hospital will have acted reasonably if it tried to find out the extent of the beneficiary's entitlement to inpatient hospital services by:

1. Asking the beneficiary or another person if the beneficiary was an inpatient of a hospital or extended care facility within the past 60 days; and

2. Requesting, if there was a prior stay, the additional information from the beneficiary or other person necessary to indicate the number of days of inpatient hospital services, if any, remaining in the current spell of illness.

3. Under unusual circumstances, reasonable grounds may be found even though the hospital has not followed the requirements of 1 and 2 above (e.g., because the patient was not in a physical or mental condition to discuss his entitlement and no other person with a knowledge of his affairs was available).

D. Prior to submitting its bill under the guarantee provision, the hospital refunds amounts received from the patient, or someone on his behalf, for the services for which the program is being billed. If the hospital

retains all or part of the payment made by the patient or someone on his behalf for services within the guarantee period it should not claim program payment for the amounts it has retained. Where the guarantee applies, the hospital should furnish an itemized statement of payments received and refunds made in connection with the bill.

286.2 Maximum Number of Days Under Guarantee.—The intermediary (or the Social Security Administration) may pay the hospital for inpatient hospital services furnished for up to 6 days after the day of admission. Saturdays, Sundays, legal Federal holidays, and the first calendar day of admittance to the hospital will be omitted in computing the 6 elapsed days. However, no payment is made for any day after the day the hospital receives a notice of lack of entitlement. The notice may be furnished by mail, messenger, wire, or telephone. If notice is given by telephone, a confirmation in writing will be furnished to the hospital; the date of the telephone message will be considered the date of notification.

In determining the days covered by the guarantee, legal Federal holidays are:

- New Year's Day
- Washington's Birthday
- Memorial (Decoration) Day
- Independence Day
- Labor Day
- Veterans Day
- Thanksgiving Day
- Christmas Day

Exclusion of Federal nonworking days prolongs the period covered by the guarantee. When a Federal holiday occurs on a Sunday, the day following is observed as a Federal nonworkday and, therefore, would not be counted as an elapsed day. When the holiday falls on Saturday, the prior Friday would not be counted as an elapsed day. The hospital will be paid on behalf of the beneficiary for all the days of inpatient services within the guarantee period; i.e., weekends, holidays, and the day of admittance will be included in computing the benefit amount due the hospital.

286.3 Recovery of Funds Advanced Under Guarantee Provision.—Benefits paid to hospitals under the guarantee provision are subject to recovery from the beneficiary unless recovery is waived. Cash benefits payable to the beneficiary under the Social Security or Railroad Retirement Act may be suspended or reduced until the amount advanced to the hospital on his behalf has been repaid.

289. WORKMEN'S COMPENSATION

Health insurance payment is excluded for any items and services to the extent that payment has been made or can reasonably be expected to be made under a workmen's compensation law or plan of the United States or a State. This exclusion applies to the workmen's compensation plans of the 50 States, the District of Columbia, and Puerto Rico, and to the Federal Employees Compensation Act and the Longshoremen's and Harbor Workers' Compensation Act. The Federal Employers' Liability Act is not a workmen's compensation law or plan under this exclusion.

Health insurance payment for items or services is conditioned on reimbursement to the hospital or supplementary medical insurance trust fund when notice or other information is received that payment has been made under workmen's compensation.

The individual is responsible for taking whatever action is necessary to obtain payment under workmen's compensation where such payment can reasonably be expected. If he fails to take proper and timely action, health insurance payment will not be made for services that **could** have been paid for under workmen's compensation. The hospital should advise the patient to file for workmen's compensation when a work-related injury or illness is indicated.

289.1 Effect of Workmen's Compensation Payments on Eligibility and Spell of Illness.—An inpatient stay in a qualified hospital or extended care facility starts a spell of illness even though workmen's compensation, rather than the health insurance program, pays or can be expected to pay for the services.

However, there is no charge against the patient's 90 days of benefit eligibility, nor the 190-day lifetime limitation on inpatient psychiatric hospital services, for days covered by workmen's compensation. When workmen's compensation pays for part of a stay and health insurance pays for services thereafter, only the days for which health insurance paid are charged against the individual's benefit eligibility.

Workmen's compensation payments cannot be counted toward the health insurance deductibles or coinsurance under either Part A or Part B. For example: If an individual is hospitalized twice in the same spell of illness and the first stay is completely paid for under workmen's compensation, the inpatient hospital deductible applies to the second stay.

289.2 General Procedures in Workmen's Compensation Cases.—An employment related illness or injury is indicated on the billing form, and the employer's name and address given.

If the patient has already received a workmen's compensation payment for the current illness or injury (e.g., for a prior hospital stay), the hospital should furnish the intermediary any available information with the admission notice, since a later hospitalization for the same condition may also be compensated under workmen's compensation. If workmen's compensation coverage is possible, a claim should be filed with the workmen's compensation carrier.

Even though workmen's compensation payment has been or probably will be made, the hospital should submit a bill to the intermediary, or to the Social Security Administration if the hospital deals directly with the Government (see § 450).

A. Workmen's Compensation Has Been or Is Being Paid.—If at the time the hospital submits its bill, workmen's compensation payment, which fully covers the cost of the services furnished, has been or is being made, no health insurance payment can be made.

A lump sum compromise awarded as payment of a workmen's compensation claim may include an amount for hospital and medical expenses. The payment under health insurance in such cases is based on the intermediary's judgment as to what workmen's compensation could reasonably have been expected to pay had the individual pursued his rights rather than accepting the compromise settlement.

The hospital will be notified by the intermediary of the extent to which its bill was covered by workmen's compensation.

B. Workmen's Compensation Is Reasonably Expected.—If, at the time the hospital submits its bill, workmen's compensation has not been or is not being paid, the intermediary will determine whether workmen's compensation can reasonably be expected to pay. If the intermediary determines that workmen's compensation payment can reasonably be expected, the hospital will be notified that health insurance payments cannot be made. The individual will also be notified of the intermediary's decision. If workmen's compensation does not ultimately pay for the services, the claim under health insurance may be reopened.

C. Workmen's Compensation Is Questionable.—If the intermediary determines that workmen's compensation payments cannot reasonably be expected, payment under health insurance will be made to the hospital on condition that the payment will be refunded if workmen's compensation later pays for the services. However, conditional payment will not be made unless there is a real question as to workmen's compensation payment. The mere fact that the em-

ployer or the workmen's compensation carrier is contesting liability is not in itself sufficient basis for conditional payment.

289.3 Overpayments.—If the hospital receives workmen's compensation payments after having received health insurance payments for the same items and services, the program must be reimbursed for the overpayment. The hospital may arrange with the intermediary to do this by refund or by adjustment of its future program payments.

290. UTILIZATION REVIEW PLAN

A qualified hospital is required to have in effect a plan for utilization review which applies to the inpatient services the hospital furnishes to patients entitled to benefits under the health insurance program. The plan must provide for review, on a sample basis, of admissions, duration of stays, and professional services furnished; and review of each case of continuous extended duration while the patient is in the hospital.

If the hospital's utilization review committee has reason to believe that an inpatient admission was not medically necessary, it may review the admission at any time. However, the decision of a utilization review committee in one hospital is not binding upon the utilization review committee in another hospital.

Payments made to physicians serving on hospital utilization review committees are considered as an allowable hospital cost **only** if the utilization review plan applies to **all** of the hospital's inpatients.

The law requires that effective utilization review be maintained on a continuing basis to assure the medical necessity of the services for which the program pays and promote the most efficient use of available health facilities and services.

The detailed requirements for an acceptable utilization review plan are set out in the "Conditions of Participation for Hospitals."

290.1 Definition of Extended Stay—Beneficiary Admitted Before Entitlement.—The general rule for the review of extended-stay cases is explained in the "Conditions of Participation for Hospitals." If an individual is admitted to a hospital before he is entitled to hospital insurance benefits (for example, before he reaches age 65), the following rules apply when he does become entitled.

In identifying cases of extended duration for review by the utilization review committee in those hospitals which provide for the review of beneficiary cases only, the patient will be considered to have been admitted to the hospital on the day he became entitled to hos-

pital insurance benefits. For example, if a hospital has defined extended stay as being 20 days of hospitalization, a patient who becomes entitled to Part A benefits on May 1, but who is admitted prior to that date, would be considered as an extended-stay case for utilization review purposes on May 21.

290.2 Further Inpatient Stay Not Medically Necessary.—If in the review of an extended-stay case the physician members of the utilization review committee decide, after opportunity for consultation is given the attending physician, that further inpatient stay is not medically necessary, notification in writing is given within 48 hours to the institution, the attending physician, and the patient. While the attending physician may, if he wishes, advise the patient personally of the utilization review committee's decision, it would still be necessary for the committee to give timely written notice of its decision to the patient. Payment cannot be made for more than 3 days of inpatient hospital services after the date the notice is received by the hospital.

290.3 Availability and Appropriateness of Other Facilities and Services.—In determining whether further inpatient hospital stay is medically necessary, utilization review committees are required to take into account the availability and appropriateness of other facilities and services. The following guidelines should be used by utilization review committees in general hospitals. (Instructions for committees in psychiatric and tuberculosis hospitals will be issued at a later date.)

A. Determining Required Level of Care.—If the committee believes that the patient no longer requires hospital care but could receive proper treatment in an extended care facility, it should determine whether there is a bed available to the patient in a participating extended care facility in the area (see C and E below). If there is, the committee should find that further stay in the hospital is not medically necessary.

If the committee determines that no bed is available to the patient in a participating extended care facility, it should find that continued stay in the hospital is medically necessary. The basis for the decision should be documented in the committee records. The committee will advise the attending physician that its decision is based on the lack of availability of a bed in a participating extended care facility; and that it is his responsibility to attempt on a continuing basis (with the assistance of the hospital's social worker,

etc.) to place his patient in a participating extended care facility as soon as a bed becomes available.

If the utilization review committee determines that the patient requires services other than inpatient hospital or extended care services (such as custodial, outpatient, or home health care), it should find, without regard to the availability of such kinds of care, that further inpatient hospital stay is not medically necessary. Covered inpatient hospital or extended care services should not be considered as an alternative to noncovered or noninstitutional services.

B. Home Health Care as an Alternative to Institutionalization.—A patient who needs either hospital or extended care services continually requires a level of care and a scope of services that can only be provided in an institutional setting. Only those institutions which meet the conditions of participation for hospitals and extended care facilities are qualified to provide them.

A patient who needs home health services requires a minimal level of services which does not call for the patient to be institutionalized. For example, an individual may only require a single service, such as physical therapy. A utilization review committee which finds that an individual only requires home health services should not recommend continued inpatient stay, even though the required services are not available to the individual because there is no agency in the community which can provide the services, or there is an agency but the individual has no home to which he can be discharged.

C. Location of Alternative Facilities.—A utilization review committee will consider what facilities are available in the community or local geographic area in deciding whether the patient can be cared for effectively elsewhere. It is not possible to define community or local geographic area with any precision. However, as a general rule, a community or local geographic area should not be defined in such a way as to require a patient to be taken away from his family and transported over great distances.

D. Patient's Financial Status and Personal Preference.—A utilization review committee should not take into account a patient's ability to pay for services or his coverage or lack of coverage under the health insurance program in deciding whether continued hospital stay is medically necessary.

A patient's preference for one extended care facility over another (such as a preference for a sectarian facility over a nonsectarian facility) should not be taken into account by the committee. If extended care facili-

ties are available but the patient's preferred facility is filled, the committee should find that further inpatient stay is not medically necessary.

E. Sources of Information on Available Participating Extended Care Facilities.—The Part A intermediary or the local social security office can supply the names and addresses of participating extended care facilities in the local area. Medical social workers, public health nurses, religious counselors, etc., can provide information about bed availability in such facilities.

290.4 Failure To Make Timely Review of Cases.—If the Social Security Administration determines, on the basis of information obtained by a State agency or by an intermediary during the course of its ongoing review of utilization practices, that a hospital has substantially failed to make timely review of long-stay cases, it may, in lieu of terminating its agreement with the hospital, decide that no payment may be made on behalf of patients for more than 20 consecutive days of inpatient hospital services. The Administration will determine the effective date of this limitation. It would apply to services provided to individuals admitted to the hospital after that date. Notice of the decision must be given to the hospital and to the public.

The limitation will be removed when it is determined that timely review of long-stay cases has been restored and there is reasonable assurance that the deficiency will not recur.

Appeals of Payment Determinations

295. HOSPITAL PROTEST OF PAYMENT DETERMINATION

The hospital and its intermediary should attempt to resolve mutually any differences involving payment that arise from the application of the cost formula or the amount payable in a specific case. No appeal is available for hospitals or other providers from intermediary payment determinations. However, provider complaints and protests will be considered in the Social Security Administration's review of the intermediary's application of the cost formula and its compliance with the other terms of its agreement with the Government.

296. BENEFICIARY PROTESTS AND APPEALS OF PAYMENT DETERMINATIONS

A. Hospital Insurance Program.—An individual dissatisfied with any determination of the amount of benefits payable on his behalf under hospital insurance may have his claim reconsidered by the Social Security Administration. If he is not satisfied with the reconsideration determination and the amount in controversy is \$100 or more, he may request a hearing by the Social Security Administration. If the amount in controversy is \$1,000 or more and he is dissatisfied with the hearing decision, the individual may initiate action for Federal court review of the claim.

B. Medical Insurance Program.—An individual dissatisfied with denial of a request for payment of medical insurance benefits, or with the amount of medical insurance benefits paid, or with the promptness with which his request for payment is acted upon is entitled to a review by, and if still dissatisfied, to a fair hearing by the medical insurance intermediary. Since the hospital is paid for the medical insurance services it furnishes by the same intermediary that makes hospital insurance payments to the hospital, this intermediary is responsible for the review and hearing under medical insurance.

A patient dissatisfied with a payment for the services of a hospital-based physician is entitled to a review by and, if still dissatisfied, to a fair hearing by the medical insurance intermediary to whom the bill for the physician's services was submitted for payment.

C. Patient protests concerning entitlement to health insurance benefits, or the denial, amount, or promptness of payment for items or services furnished by the hospital under hospital or medical insurance should be handled, if simply amenable to explanation or correction, by the hospital. If the patient wishes to protest the health insurance determination on his request for payment or the promptness of payment, he should be referred to his social security district office. The district office can offer assistance to the beneficiary in determining his appeal rights and can answer specific questions about the appeal procedures. The district office can also assist the individual in completing the necessary forms for requesting reconsideration or hearing.

Emergency Hospital Services

H202. DEFINITION OF EMERGENCY HOSPITAL

The amendments provide a new definition of the term "hospital" for purposes of payment for emergency hospital services. The new definition, which will permit additional institutions to qualify as emergency hospitals, is effective July 1, 1966. Therefore, benefits will be payable for emergency hospital services rendered since the program began in such hospitals if the hospital requests payment. Aside from the change in definition of an emergency hospital, all rules in effect before enactment of the amendments will apply to emergency services if the hospital admission took place before January 1, 1968 (additional changes take effect at that time). Emergency outpatient hospital diagnostic benefits furnished prior to 1968 by hospital which meet the new emergency hospital definition will similarly be payable.

The new definition of an emergency hospital requires that the hospital must meet the requirements of the law's definition of a "hospital" relating to full-time nursing services and licensure under State or applicable local law. See § 200 e and g. (A Federal hospital need not be licensed under State or local licensing laws to meet the definition of emergency hospital. This policy applies to claims processed under the prior law as well as those under the amendments.) In addition, the hospital must be primarily engaged in providing, under the supervision of doctors of medicine or osteopathy, services of the type that section 200a describes in defining the term hospital, and must not be primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care. (See the definition of an extended care facility in § 110.2.) Psychiatric and tuberculosis hospitals that meet the above hospital requirements can qualify as emergency hospitals.

The new definition of an emergency hospital is the same definition of "hospital" that will be used henceforth in determining whether an individual has met the 3-day hospital stay requirement for purposes of entitlement to have payment made for posthospital extended care or home health benefits. The new definition for this purpose will apply to hospital discharges occurring on or after January 1, 1968.

H202.1 Payment for Emergency Inpatient Hospital Services.--
Effective for hospital admissions on or after January 1, 1968, nonparticipating hospitals which meet the emergency hospital requirements will be given an opportunity to elect to request payment from the program for all emergency services rendered to beneficiaries in a calendar year. If a hospital so elects, reimbursement will be made to it in accordance with existing procedures for emergency hospital services.

Where the hospital has not elected to bill the medicare program, payment may be made to the beneficiary, based on an itemized bill, for emergency inpatient hospital services. (For earlier emergency hospital admissions where the hospital does not bill the program, the patient may bill the program and receive benefits under the temporary provision applicable to services furnished by nonparticipating hospitals. See § H208.)

If the hospital elects not to request payment from the program, reimbursement will be made to the beneficiary, based on an itemized bill. The reimbursement amount will be equal to 60 percent of the hospital's reasonable charges for routine services plus 80 percent of the reasonable charges for ancillary services for covered days in the spell of illness, subject to the regular Part A deductible and coinsurance. If the hospital does not make separate charges for routine and ancillary services, payment will be made to two-thirds of the hospital's reasonable charges for the services received (not to exceed charges based on semiprivate accommodations), subject to deductible and coinsurance.

"Routine services" means the regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment and facilities for which a separate charge is not customarily made. Charges for semiprivate accommodations or the room occupied, whichever is less, will be the basis for the routine charges allowed. "Ancillary services" means those covered special services for which charges are customarily made over and above those for routine services.

H202.2 Payment for Emergency Outpatient Services.--The hospital's election to request payment from the program applies to emergency outpatient hospital services as well as to inpatient services. Where the hospital has not so elected, payment may be made to the beneficiary, as in the case of inpatient services, for outpatient emergency services furnished on or after January 1, 1968. Reimbursement to the beneficiary will be equal to 80 percent of the hospital's reasonable charge, subject to the applicable deductible and coinsurance.

The amendment provision permitting hospitals to collect in full from the patient certain small outpatient bills applies **only to participating hospitals**. Therefore, emergency outpatient hospital services are not subject to the small outpatient bill procedure.

Until April 1, 1968, outpatient emergency hospital coverage is limited, as under the 1965 law, to outpatient hospital diagnostic services. Such services become covered under Part B as of April 1. Also on April 1, outpatient hospital therapeutic services (hospital services incident to physicians' services rendered to outpatients) become payable in emergency cases when furnished to outpatients by an emergency hospital.

Retroactive Payment for Services in Nonparticipating Hospitals**H208. SERVICES FURNISHED BY NONPARTICIPATING HOSPITALS--TEMPORARY PROVISION**

A. General.--Under a temporary and largely retroactive provision of the amendments, **payment may be made to beneficiaries** under Part A on the basis of an itemized bill for certain inpatient hospital services furnished them by, or under arrangements made by, nonparticipating hospitals. The provision applies to inpatient hospital services furnished after June 30, 1966, and before January 1, 1968, (except that payment can be made for services furnished after 1967 where the hospital admission took place before January 1, 1968).

Payment can be made only if, when the services were furnished, the hospital met the new definition of the term "hospital" for emergency purposes (see H202). The hospitalization need not have been for emergency treatment. However, where a hospital chooses not to bill the program for emergency inpatient services, the beneficiary may file for payment for the hospital stay under this provision. (Ordinarily, payment for emergency inpatient services should be made under the emergency hospital coverage provisions of law where that is feasible rather than under the temporary provision permitting payment to the patient, because payment under the latter provision will generally result in more limited reimbursement for the services.)

Payment for services under the temporary provision will be made by the Part A intermediary designated to handle payment for emergency hospital services. If the hospital is now participating, its nominated intermediary will process the claim.

Since the patient must file for benefits under this provision, the hospital should provide him with an itemized bill or ledger sheet covering the charges for the inpatient services he received during the retroactive period. ~~The bill or ledger sheet should show the discharge diagnosis and whether the services were paid for by workmen's compensation or a welfare program.~~ **unless this information should not be disclosed to the beneficiary** If the inpatient stay exceeded 20 days and the hospital is now participating, the utilization review determination required by subsection D.1 below should also be indicated. The hospital should refer the beneficiary to his social security district office to file his claim. Application for reimbursement under this provision must be filed before January 1, 1969.

B. Scope of Benefit.--Payment under the temporary provision may be made for 20 days of inpatient hospital services in each

spell of illness, less any days in excess of 70 for which the beneficiary is otherwise entitled to have payment made (the total can thus not exceed 90 days). In addition, if the hospital becomes a participating hospital before January 1, 1969, and if the hospital applies its utilization review plan to the services for which reimbursement is claimed (see D.1 below), payment may be made for up to 90 days of inpatient hospital services in each spell of illness (less any days for which the beneficiary is otherwise entitled to have payment made).

The reimbursement amount for inpatient hospital services covered under the temporary provisions will be calculated on the same basis as under the provision of the amendments permitting reimbursement to the beneficiary for certain emergency hospital services where the hospital admission was after 1967 (see § H202.1). In general, reimbursement will be equal to 60 percent of the hospital's reasonable charges for routine services plus 80 percent of the reasonable charges for ancillary services, subject to applicable deductible and coinsurance amounts for the covered days.

C. Spell of Illness.--Under the prior law, a beneficiary's stay in a hospital meeting the definition of an emergency hospital could begin a spell of illness only if the hospital services were emergency inpatient services. For purposes only of the temporary provision in the amendments described above, a stay in an institution meeting the definition of an emergency hospital can begin a spell of illness even where the inpatient services furnished were not emergency services. Therefore, in determining whether, and for how many days, inpatient hospital benefits are payable under the temporary provision, a spell of illness can be considered to have begun earlier than was previously established--e.g., when a stay in an emergency hospital preceded a stay in a participating hospital and less than 60 days separated the two hospital stays.

For example, Mr. B was an inpatient of a nonparticipating hospital for 20 days in July 1966; he was home during August; in September he spent 30 days in a participating hospital; in October he was home all month; beginning November 1, he spent 60 days in a participating hospital.

Mr. B has used up his 90 days of inpatient hospital coverage through stays in participating hospitals in the spell of illness that began in July 1966. No payment can be made to him under the temporary provision for the 20 days in the nonparticipating hospital, although they preceded the days spent in participating

hospitals in the same spell of illness. If Mr. B had used up only 80, instead of 90, days in participating hospitals in the spell of illness, payment could have been made, under the temporary provision, for 10 of the days he spent in the nonparticipating hospital. Note that these 10 days would be subject to coinsurance (but not to the deductible) despite occurring earlier in the spell of illness than days that were not subject to coinsurance.

D. Applicability of Various Provisions of Medicare to the Temporary Provision.--As a general rule, provisions of the medicare law, such as those relating to conditions and limitations on payments, will apply to services covered under the temporary provision. The applicability of other medicare provisions is discussed below:

1. Utilization review.--The hospital's utilization review plan may not become operative until after the retroactive period covered by the temporary provision. The hospital will be asked to examine its records in connection with an individual's claim for reimbursement for more than 20 days in one spell of illness and furnish a determination regarding the need for inpatient hospital services for the period covered by the claim.

2. Services previously paid for by a welfare program or a private insurer.--No payment may be made for any services furnished in a nonparticipating hospital in the retroactive period where these services have been paid for by a public welfare plan or program. The fact that a private insurer may have paid the bill will not affect the beneficiary's right to reimbursement under medicare.

3. Physician certification is not required for services covered under the temporary provision.

4. The workmen's compensation provisions apply.

5. Reimbursement will not be made for services furnished by a Federal hospital.

6. The psychiatric and tuberculosis hospital reduction provision applies. (The reduction provisions under prior law apply to services furnished before 1968. See § 217.) Thus, payment could be prevented for the inpatient hospital services that would otherwise be covered by the temporary retroactive

provision if the services were furnished in the patient's first spell of illness and the patient had been an inpatient of a participating psychiatric or tuberculosis hospital on his date of entitlement. However, if on entitlement the patient was in a general hospital or a nonparticipating hospital, the psychiatric and tuberculosis reduction would not apply and could not prevent payment.

For example, on July 1, 1966, an entitled individual was in a participating psychiatric hospital and had been there during all of the preceding 90 days. Later in July, in the same spell of illness, he entered a nonparticipating hospital which met the new definition of "hospital" for emergency services purposes as provided in the amendments. No retroactive benefits are payable for the stay in the nonparticipating hospital since the reduction provision would apply and under it the individual would be considered to have used up his 90 days of inpatient hospital benefits in his first spell of illness.

If, however, on July 1, 1966, the individual had been in a nonparticipating hospital, the carry-over provision would not apply; benefits would be payable retroactively, in accordance with the amendments, even though he had spent the 90 days prior to July 1 in a psychiatric hospital.

7. The custodial-care exclusion applies.

Additional Days of Hospital Care

H216. ADDITIONAL DAYS OF HOSPITAL CARE

A. General.--The amendments provide that a beneficiary is entitled to have payment made on his behalf for up to 150 days of inpatient hospital services during a single spell of illness minus 1 day for each day of such services in excess of 90 received during any prior spell of illness. Thus, each beneficiary will have a lifetime reserve of 60 additional days of inpatient hospital services to draw upon whenever he has used 90 days of inpatient hospital services in a spell of illness. Payment will be made for such additional days of care unless the individual elects not to have such payments made (and thus save his reserve days for a later time). The amount payable for inpatient hospital services for each of the "reserve" days is reduced by a coinsurance amount of \$20 (one-half of the inpatient hospital deductible). The lifetime reserve provision applies to services furnished after December 31, 1967.

Under the amendments, the guarantee of payment provisions are not applicable until the individual has exhausted his 60 additional days of inpatient hospital services. (See section 286.)

B. Election by Beneficiary.--The beneficiary has the option of electing not to have the program pay for additional days of inpatient hospital services furnished him after he has received benefits for 90 days of such services in a spell of illness. Hospitals are required to notify the beneficiary of his right to make such an election before billing the program for inpatient hospital services furnished after the 90th day in a spell of illness. Hospitals should appropriately annotate their records at the time they inform a beneficiary of this option. Payment may be made for reserve days of services on the basis of the beneficiary's signature on the admission form, unless the patient has indicated specifically by a statement in writing that he does not wish to use any of his reserve days. It follows that a hospital may not charge a beneficiary more than the coinsurance amount for inpatient hospital services furnished after the 90th day of such services in a spell of illness and through the 150th day unless it has on record such a statement.

C. Spell of Illness Beginning Before 1968.--Reserve days may be used even where the spell of illness begins before 1968.

1. A beneficiary who has used up 90 days in a spell of illness in 1967 and is still in the hospital during the same spell of illness on January 1, 1968, can use reserve days beginning January 1, 1968.

2. A beneficiary who has used up 90 days in a spell of illness in 1967, leaves the hospital before the end of that year, and returns to the hospital in 1968, in the same spell of illness, may use reserve days as soon as he returns to the hospital.

3. If a beneficiary has used up 90 days before the end of 1967 and is still in the hospital on January 1, 1968, during the same spell of illness, and on such day begins using his reserve days, January 1, 1968 will not be treated as a day of care if he is discharged on that day (reimbursement can be made in accordance with existing rules on day of discharge). If he is not discharged on that day, it will be treated as a day of admission for purposes of counting days of utilization.

D. Availability of Reserve Days.--As a general rule, no reserve day will be counted if the beneficiary is not entitled to have payment made.

Thus, the reserve days are not available to a beneficiary who has been in a psychiatric hospital for the 150 days before the first day of entitlement to health insurance benefits and on the first day of entitlement is still in such hospital.

The reserve days are also not available to a beneficiary who uses up 190 days of inpatient psychiatric hospital care without having used any reserve days and remains in or re-enters a psychiatric hospital. If such a beneficiary needs general hospital services or tuberculosis hospital services, the reserve days will be available to him for such services.

A beneficiary will be deemed to have elected not to use his lifetime reserve to cover inpatient days for which the hospital's daily charge is equal to or less than the coinsurance amount. Such days are treated as noncovered days. For example, reserve days will not be available to a patient of a psychiatric hospital whose daily charge is \$15 (the amount the patient is obligated to pay would remain \$15 regardless of his election). This rule is contrary to the rule which remains in effect for the 61st through 90th day; the beneficiary cannot elect to have such days treated as noncovered days, and in some instances the hospital may be reimbursed for them. See Section 402.1, item 26 for billing instructions in these cases.

E. Physician Certification.--Physician certification requirements, as modified by the 1967 amendments (see § 273ff.) are applicable to lifetime reserve days.

If a period of time elapses during which the beneficiary remains in the hospital after exhausting his 90 days of benefits and before additional days become covered under the lifetime reserve, the timing of the required certification is determined from the date on which the beneficiary was admitted to the hospital.

For example, Mr. A was admitted to the hospital on December 1, 1967, having previously used 90 days of inpatient hospital benefits in his spell of illness. Since his benefits were exhausted before his 14th day of stay, no physician recertification was made as of that day, nor was there recertification as of the 21st day. The beneficiary becomes entitled on January 1, 1968, to have payment made for up to 60 additional days. Physician certification is then required as of the 51st day of his hospital stay (the 30th day following the 21st day, unless the hospital's utilization review committee has specified that more frequent certifications be made). Thus, if Mr. A remains in the hospital until then, physician certification is required as of January 20.

Psychiatric Hospital Reduction Provision**H217. REVISION OF THE REDUCTION PROVISION FOR PATIENTS OF
PSYCHIATRIC AND TUBERCULOSIS HOSPITALS ON FIRST DAY OF
ENTITLEMENT**

Effective January 1, 1968, the amendments modify the reduction provision in three major respects:

1. An individual who was an inpatient of a tuberculosis hospital on the first day of his entitlement to hospital insurance is not subject to a reduction in benefit days in his first spell of illness. Thus, only inpatients of participating psychiatric hospitals upon entitlement are still subject to the reduction.
2. The period immediately preceding the first day of entitlement which must be considered for the reduction and the number of days which may be subtracted in the first spell of illness are increased from 90 to 150 days. (This conforms with the provision in the amendments providing a lifetime reserve of 60 days of inpatient hospital benefits. See § H216.)
3. When the patient's benefit days are subject to reduction in the first spell of illness, the reduction still applies to inpatient days in a psychiatric hospital. However, the reduction now applies to inpatient days in a general hospital only if the individual was an inpatient primarily for the diagnosis or treatment of mental illness. Thus, an individual subject to the reduction may nevertheless be entitled to have payment made for up to 150 days of inpatient hospital services in a tuberculosis hospital or for a non-mental illness in a general hospital during his first spell of illness.

For services furnished after December 31, 1967, the reduction provision will be applied in accordance with the instructions given below. To the extent that existing instructions are not modified by the material below, they remain in force. Payment for services furnished prior to 1968 will be made on the basis of existing instructions.

A. Determining Days Available - Date of Entitlement After 1967.--

The patient will be eligible to have payment made for inpatient psychiatric hospital services and inpatient hospital services primarily for the diagnosis or treatment of mental illness in the first spell of illness only for the number of days remaining after the reduction is applied. To determine the number of days available in the first

spell of illness to pay for inpatient psychiatric hospital services and inpatient hospital services for the treatment of mental illness, the following steps should be taken:

1. determine how many days in the 150-day preentitlement period the patient spent in a psychiatric hospital
2. subtract these from 150

Payment should be made for the remaining days in the following order of priority:

- a. the 60 full benefit days,
- b. the 30 coinsurance days at \$10,
- c. the 60 lifetime reserve days.

Benefit days, including lifetime days, not available to the patient because of the psychiatric reduction nevertheless remain available for use in hospitalization not subject to the reduction: a general hospital stay for a nonpsychiatric condition or a tuberculosis hospital stay. The lifetime days not previously used also remain available for any inpatient stays (including psychiatric hospital stays) in subsequent spells of illness.

EXAMPLE 1: The patient was an inpatient of a participating psychiatric hospital on his first day of entitlement on February 1, 1968. He had been in such a hospital in the preentitlement period for 20 days. Therefore, 130 days are payable. Payment would be made in the following order: 60 full benefit days; 30 \$10 coinsurance days; 40 \$20 coinsurance (lifetime) days.

EXAMPLE 2: The same facts as in example 1, except that the patient had been in a psychiatric hospital in the preentitlement period for 70 days. Therefore, 80 days are payable. Payment would be made in the following order: 60 full benefit days; 20 \$10 coinsurance days.

EXAMPLE 3: The same facts as in example 1, except that the patient had been in a psychiatric hospital in the preentitlement period for 110 days. Therefore, 40 days are payable. Payment would be made for these 40 days as full benefit days.

Psychiatric Hospital Investigation of 150-Day Pre-entitlement Period.-- For admissions on or after January 1, 1968, the psychiatric hospital has the responsibility of investigating the 150-day preentitlement period only if the patient becomes entitled to hospital insurance while in this hospital. The information about preentitlement psychiatric stays will be entered in item 12 of the SSA-1485. Item 12 will be modified by deleting the words "or tuberculosis institution" and changing "90" to "150."

In some cases it may be necessary for the intermediary to recontact the hospital if only the 90 days preentitlement period was investigated and a reduction in days applies.

B. Determining Days Available - Date of Entitlement Before 1968 - Patient Still in First Spell of Illness.--

1. An individual who after December 31, 1967, is still in his first spell of illness and was subject to a reduction in benefit days prior to 1968 because he was in a participating tuberculosis hospital at the time of Part A entitlement will have those days restored for any inpatient hospital services furnished after December 31, 1967. The reduction provision no longer applies to such an individual for services furnished after 1967. Thus, for example, an individual who was an inpatient of a tuberculosis hospital on his date of entitlement and for the 90-day period preceding entitlement, would be eligible on January 1, 1968, for up to 150 days of any inpatient hospital services in his first spell of illness.

2. A beneficiary who after December 31, 1967, is still in his first spell of illness and was subject to a reduction in benefit days prior to 1968 because he was in a participating psychiatric hospital upon entitlement, may be entitled to additional benefit days beginning January 1, 1968.

a. On January 1, 1968, the individual becomes eligible for 60 lifetime reserve days. Before these days can be used for psychiatric hospital stays or general hospital stays for the treatment of mental illness, an investigation of the 91st to 150th day period preceding entitlement must be made. Any days spent in a psychiatric hospital during this period will have to be subtracted from the 60 lifetime reserve days available for use **in the first spell of illness.**

Prior to 1968, the number of benefit days available in the patient's first spell of illness was determined on the basis of the 90-day period preceding entitlement (§ 217). The rules in A above do not

apply and a new determination will not be made for this period. Payment, if any, for psychiatric hospital stays and general hospital stays for the treatment of mental illness on or after January 1, 1968, will be made for any days still payable under the prior determination and then for any lifetime reserve days available as determined above. (However, a new determination for the 90 day preentitlement period will be required if there is evidence that tuberculosis hospital days were included in the prior determination. See c below.)

EXAMPLE 1: An individual was in a participating psychiatric hospital when he became entitled to benefits on December 1, 1967, and remained in the hospital following entitlement. Since he had been in the hospital for all of the 90-day preentitlement period, he was not entitled to benefits for the services he received in 1967. On January 1, 1968, he became entitled to 60 lifetime reserve days. An investigation of the 91st to 150th day preceding entitlement disclosed he was in a psychiatric hospital for 30 days in that period. He may use 30 lifetime days for his stay in the psychiatric hospital beginning January 1, 1968.

EXAMPLE 2: Same facts as example 1, except that in the 90-day preentitlement period the individual was in a psychiatric hospital only 30 days. He was, therefore, eligible under prior law for payment of 60 full benefit days. On January 1, 1968, 31 of the 60 full days had been used. On January 1, 1968, he is eligible to have payment made for 29 full benefit days and then 30 lifetime days.

b. Any unused benefit days plus the number of days for which the beneficiary's eligibility was previously reduced plus 60 lifetime reserve days are available for general hospital stays for a non-psychiatric condition or for tuberculosis hospital stays in the first spell of illness.

c. Days spent in a tuberculosis hospital in the preentitlement period do not count as reduction days for services received after 1967 and such days are restored. This is true not only for a beneficiary who was in a tuberculosis hospital when he became entitled but also for a beneficiary who was in a psychiatric hospital at the time of entitlement after having spent some of his preentitlement days in a tuberculosis hospital. However, in the latter situation

a presumption may be made in the absence of evidence to the contrary that all days in the preentitlement period were psychiatric hospital days.

C. Services Primarily for the Diagnosis or Treatment of Mental Illness.--When an individual subject to a reduction in days is an inpatient in a general hospital after December 31, 1967, the intermediary will apply the reduction only if it has determined that the individual was an inpatient primarily for the diagnosis or treatment of mental illness.

The intermediary will make a tentative decision based on the admitting diagnosis (Item 14, Form SSA-1453). This decision will be subject to change, however, based on reports from the hospital or other information received by the intermediary. Hospitals should notify the intermediary of any subsequent developments that might cause the intermediary to modify the initial decision. Where the patient receives treatment not only for mental illness but also for another condition, the intermediary will determine for which condition the individual was primarily an inpatient.

The intermediary will also examine the discharge diagnosis when the bill is received to see if a change occurred during the period of hospitalization. The reduction will not be applied where the primary discharge diagnosis is not related to mental illness, even though the reduction was tentatively applied based on the admitting diagnosis.

If the intermediary needs more information to make the required determination, it will obtain it from the hospital, the attending physician, or other appropriate source.

The term "mental illness," is defined as the specific psychiatric conditions described in the American Psychiatric Association's Diagnostic and Statistical Manual--Mental Disorders.

NOTE: The references to tuberculosis hospitals and treatment for tuberculosis in section 217.ff. of the Hospital Manual are not applicable after December 31, 1967.

Definition of Blood

H222 CHANGE IN DEFINITION OF BLOOD FOR PART A BLOOD DEDUCTIBLE

A. For blood furnished on and after January 1, 1968, the Part A blood deductible applies not only to the first 3 pints of whole blood but also to equivalent quantities of packed red blood cells. Where packed red cells are furnished, a unit of packed red cells is considered equivalent to a pint of whole blood. As under previous law, plasma or other components of blood are not subject to the blood deductible. See § 222A.

Except for the change in the definition of blood, the policies in the present § 222 continue in effect.

Outpatient Hospital Services
Covered Under Supplementary
Medical Insurance

H230. OUTPATIENT HOSPITAL SERVICES

Effective with services furnished on or after April 1, 1968, coverage of outpatient hospital diagnostic services is transferred from Part A to Part B. Thus, all covered outpatient hospital services, as well as physicians' services to outpatients, will be reimbursable under Part B subject to the \$50 annual deductible and 20 percent coinsurance, and if applicable, the Part B blood deductible. (All special payment provisions previously applicable to outpatient hospital diagnostic services under Part A--the 20 day diagnostic study, \$20 deductible and 20 percent Part A coinsurance--will be eliminated.)

Prior to April 1, 1968, outpatient hospital services are reimbursable only when furnished by or under arrangements made by a participating hospital or when furnished as emergency outpatient hospital diagnostic services by a nonparticipating hospital which meets the definition of an "emergency" hospital. Under the amendments, coverage of emergency outpatient hospital services will include therapeutic as well as diagnostic services. Coverage of nonemergency outpatient hospital services and supplies furnished incident to a physician's service will continue to be limited to those furnished by or under arrangements made by participating hospitals.

The amendments make no change in the scope of outpatient hospital service coverage except as noted in H241 below. Therefore, in determining coverage of a particular item or service furnished to an outpatient, previously established rules (see primarily sections 232 and 240 of the Hospital Manual) should be applied. In general, such coverage includes:

A. Diagnostic Services.--Include all services and supplies in connection with diagnostic procedures (including any drugs and biologicals required in the performance of such procedures) furnished by or under arrangements made by the hospital, if furnished in the hospital or in other facilities or locations under the supervision of the hospital or its organized medical staff. (Independent laboratory services furnished to an outpatient under arrangements with the hospital will continue to be covered only under the "diagnostic laboratory tests" provisions of Part B but may be billed along with other outpatient services.)

B. Hospital Services Incident to Physicians' Services
Rendered to Outpatients.--Include services and supplies (including use of hospital facilities) furnished on a physician's order by hospital personnel under hospital medical staff supervision in the hospital or, if outside the hospital, under the personal supervision of a physician who is treating the patient. Drugs and biologicals furnished to outpatients for other than diagnostic purposes are includable only if they are of a type which cannot be self-administered.

Physical Therapy Services Furnished to Outpatients
Covered Under Medical Insurance

H241. OUTPATIENT PHYSICAL THERAPY SERVICES

Effective July 1, 1968, coverage of physical therapy as an outpatient hospital service will be expanded to include services furnished by hospital personnel outside the hospital without personal physician supervision. (See § 240.2A for present coverage of outpatient physical therapy services.)

Coverage under Part B of physical therapy furnished on an outpatient basis will also be expanded by including such services furnished by or under arrangements made by any participating provider of services. For the purposes of this coverage, the term "provider of services" is extended to include approved clinics, rehabilitation agencies, and public health agencies as well as participating hospitals, extended care facilities, and home health agencies. To qualify as providers of services, clinics, rehabilitation agencies, and public health agencies will be required to meet certain conditions enumerated in the law and to enter into an agreement with the Secretary in which they agree not to charge any beneficiary for covered services for which the program will pay and to refund any erroneous charges made. Reimbursement for these outpatient physical therapy services will be made to the provider on a cost basis. The patient will be responsible only for the regular Part B deductible and coinsurance amounts (i.e., the annual \$50 deductible and 20 percent coinsurance).

Payment may be made for outpatient physical therapy services furnished by a participating provider of services on or after July 1, 1968, only where a physician has certified that (1) such services are or were required because the individual needed physical therapy services on an outpatient basis, (2) a plan for furnishing such services has been established and is periodically reviewed by the physician, and (3) such services are or were furnished while the individual is or was under the care of a physician. In addition, the plan of treatment established by the physician must prescribe the type, amount and duration of the physical therapy services to be furnished the individual.

This new provision represents an extension of coverage in that under prior law individuals who are not homebound and, therefore, are ineligible for home health benefits can secure outpatient physical therapy services only if provided as an incident to a physician's services (i.e., provided under his personal supervision with the charges for such services included in the physician's bill) or as a hospital service furnished incident to a physician's services.

Beginning with services furnished on or after July 1, 1968, such individuals may secure outpatient physical therapy from any participating provider of services without the requirement that the services be furnished incident to a physician's services. Such services may be furnished an eligible outpatient in his home (including an institution serving as his place of residence such as an old-age home) or on the premises of the provider. Also, the inpatient of a nonparticipating institution which meets at least the basic definition of a hospital or extended care facility may receive outpatient physical therapy furnished by a participating provider of services.

Inpatients of participating hospitals or extended care facilities who have exhausted Part A benefits, or who are ineligible for Part A benefits, or who are in an institution which does not furnish physical therapy may receive physical therapy as an outpatient of another participating provider of service. For example, an inpatient of a participating extended care facility who has exhausted his benefit days may be furnished covered outpatient physical therapy by a participating hospital. While the inpatient of one provider may be considered the outpatient of another, it should be noted that since this is an outpatient benefit a participating provider of services may not furnish "outpatient physical therapy" to its own inpatient.

Podiatrists' Services

H245. PODIATRISTS AS PHYSICIANS

Effective January 1, 1968, coverage of physicians' services is extended to include services performed by podiatrists. The intent of the amendments is to allow payment for certain foot care services whether furnished by a doctor of medicine, osteopathy, or podiatry (to the extent that each is legally authorized to perform the services). Certain foot care services (including routine care), however, are excluded regardless of who performs them. (See § H261.)

H245.1 Scope of Coverage of Podiatrists' Services.--Podiatrists (chiropractors) are included within the definition of "physician" (except as indicated in H245.2 but only with respect to those functions which they are legally authorized to perform in the State in which they perform them. This means that the professional services provided by a podiatrist within the scope of his applicable State license (except those services which are specifically excluded) are "physicians' services," reimbursable on a reasonable charge basis under Part B.

Podiatrists may hold any of the following professional degrees, of which the first three are the most common: Pod.D. or D.P. (Doctor of Podiatry), D.S.C. (Doctor of Surgical Chiropody), D.P.M. (Doctor of Podiatric Medicine), D.S.P. (Doctor of Surgical Podiatry), Graduate in Podiatry, Master Chiropractor, or in a very few instances another podiatry degree. Within a particular State, all individuals holding any of these degrees are licensed to perform the same functions; however, there are variations from State to State as to the authorized scope of podiatric practice.

A. Provider-Based Podiatrists' Services (§ 255).--Some podiatrists render services as employees of or under arrangements with hospitals; these services have been reimbursed as provider services on a reasonable cost basis under the 1965 law. Under the amendments, however, podiatrists are "physicians" and therefore their professional services for individual patients are reimbursable only on a reasonable charge basis as "physicians' services" under Part B. Hospitals will not be able to include payments made to podiatrists for such services (rendered on and after 1/1/68) as part of their allowable costs (regardless of whether the podiatrist's professional services are covered under Part B). The covered services in a hospital setting of those podiatrists who already have financial arrangements, with hospitals as well as those who subsequently establish such arrangements, will

be subject to the principles of reimbursement for hospital-based physicians. (See § 255 and the regulations concerning the Principles of Reimbursement for Provider Costs and for Services by Hospital-Based Physicians §§ 405.480 - 405.488.)

B. Interns and Residents (§ 236C).--A few hospitals have podiatry internship and residency programs. Such podiatry teaching programs are not included in the statute's enumeration of "approved" teaching programs whose costs are reimbursable under Part A. Therefore, services of podiatry interns and residents will be subject to the principles governing reimbursement for the services of interns and residents who are not under approved teaching programs, i.e., such services are reimbursable to the hospital on a reasonable cost basis under Part B. The services of podiatry interns and residents are not reimbursable on a reasonable charge basis even though such individuals may be legally authorized to practice as podiatrists.

H245.2 Services for Which Podiatrists Are Excluded From the Definition of Physician.--

A. Physician Certification and Recertification of the Need for Provider Services (§ 273).--A podiatrist is not a "physician" for the purpose of making the required physician certifications and recertifications of the medical necessity for Part A and Part B provider services. This means that a medical doctor (or osteopath) must complete the certification of necessity for provider services where such certifications are required. (See section H273.) However, no certification by a medical doctor is required with respect to a podiatrist's professional services to his patients.

B. Utilization Review (§ 290).--A podiatrist is not a "physician" for the purpose of serving in the capacity of one of the two "physician" members required for hospital and extended care facility utilization review committees. He is not prohibited, however, from serving in the capacity of a nonphysician member. Final utilization review determinations of medical necessity for the full range of provider services should be made by "physicians" who are competent to assess a patient's total medical care situation. However, in the case of a podiatric patient, it is expected that the utilization review committee would consult with the podiatrist as well as the certifying physician before making a determination that further inpatient care is not medically necessary.

H245.3 Coverage of Services and Supplies Incident to the Services of Podiatrists (§ 240.2).--Established policies for determining when supplies and services are covered as incident to a physician's services in his office, a clinic, or a hospital outpatient department generally apply. However, services and supplies are covered under this provision only if they are incident to covered professional services. Further, the incidental items and services themselves should be carefully evaluated to determine whether they fall within the foot care exclusions, particularly services which may be in connection with corrective footwear and routine hygienic care. (See section H261.] for instructions concerning application of the foot care exclusions to provider services with particular reference to outpatient hospital services.)

Blood Deductible Under Medical Insurance

H249 PART B BLOOD DEDUCTIBLE

Effective for services furnished on or after January 1, 1968, a deductible under Part B is applicable to the first 3 pints of whole blood or equivalent quantities of packed red cells received by a beneficiary from all sources in a calendar year. See § 240.2B1. The definition of blood and replacement policies are the same as under Part A, except that the deductible applies on a calendar year basis. See § 222ff.

Expenses incurred in meeting the blood deductible do not count as "incurred expenses" under Part B for purposes of meeting the \$50 annual deductible or for reimbursement purposes. Even though the Part B blood deductible for any calendar year is satisfied in whole or part during the last three months of that calendar year, there is no carry-over of credit toward the blood deductible in the following calendar year. The Part A and Part B blood deductibles are applied separately regardless of whether one or the other has been met.

Radiological and Pathological ServicesH255. RADIOLOGICAL AND PATHOLOGICAL SERVICES TO HOSPITAL
INPATIENTS

Effective April 1, 1968, reimbursement will be made under Part B for the full reasonable charge for radiological and pathological services furnished to inpatients of a qualified hospital, that is, a hospital which meets all of the medicare conditions of participation, by a physician in the field of radiology or pathology. This means that 100 percent reimbursement will be made for the reasonable charges for such services, subject to neither the usual deductible nor coinsurance features of Part B. Expenses incurred under this provision of the 1967 amendments will not count toward the fulfillment of the regular \$50 Part B deductible.

A. Billing for Radiological and Pathological Services to Hospital Inpatients.--Where the physician has authorized the hospital to bill on his behalf, it will not be necessary on a patient-by-patient basis to break down the bill into professional and hospital components. (The current procedures on authorization by physicians for providers to accept assignment and receive payments on their behalf apply to this new provision of the law.) Reimbursement for the combined charge will be made to the hospital on an interim basis by the Part A intermediary from the Part A funds. Adjustments between the Part A and Part B trust funds will be made on the basis of audited costs.

On the other hand, where a claim is made for the professional component, reimbursement for professional services is made from Part B funds by the Part B carrier; thus, no adjustment between the trust funds is necessary. As in the past, reimbursement for the hospital component of these services will be made by the Part A intermediary. The physician may, if he so chooses, accept assignment and submit a single bill to the program for the full reasonable charge for his professional services. In such cases, the physician would not have to look to the patient for additional payment. If the physician bills the beneficiary without accepting an assignment, the beneficiary will receive reimbursement from the program for the physician's full reasonable charge. The hospital and the physician are free to decide whether the charges for the physician's services are to be billed by the hospital or by the physician, as well as to determine the additional elements of the parties' financial arrangements with each other.

B. Field of Radiology or Pathology.--A physician in the "field of radiology or pathology" includes not only a specialist in one of those fields, i.e., a radiologist or pathologist, but also a physician who normally performs or supervises the radiological or pathological services for patients of a particular hospital, even though the physician does not otherwise specialize in radiology or pathology. An example of this situation is a small hospital which has no radiologists but designates another physician to handle or supervise the hospital radiological procedures. The full reasonable charge for the radiological services of this physician rendered in such a capacity would be covered. On the other hand, the reading of an x-ray film as part of his usual services for his own patients by, for example, an attending physician or surgeon would normally be covered only as regular physicians' services, i.e., the basis for reimbursement would be 80 percent of the reasonable charge, subject to the \$50 deductible.

Exclusion of Refractive Services

H260.7 Exclusion of Eye Care Services.--Effective January 1, 1968, the amendments expand the scope of the eye care exclusion contained in the present law by also excluding from coverage procedures performed during the course of any eye examination to determine the refractive state of the eyes. Thus, expenses for all eye refraction procedures, whether performed by an ophthalmologist (or any other physician) or by an optometrist and without regard to the reason for the performance of the refraction, are excluded from coverage under the program.

Exclusion of Foot Care

H261. EXCLUDED FOOT CARE SERVICES

The amendments limit the scope of covered foot care services by excluding the following types of services under both Part A and Part B, effective January 1, 1968.

A. Treatment of Flat Foot Conditions and Prescription of Supportive Devices Therefor.--For the purposes of this exclusion, treatment of "flat foot conditions" means treatment of the local condition of flattened arches regardless of the underlying pathology causing it, except where such treatment is purely incidental to and an integral part of covered foot treatment (for example, treatment of a fracture). The term "treatment" encompasses all phases of services in connection with flat feet, including evaluations as well as any measures or devices designed either to correct the condition or to palliate pain and other symptoms associated with the condition.

B. Treatment of Subluxations of the Foot.--For the purposes of this exclusion, the term "subluxation" refers to structural misalignments of the feet (except fractures and complete dislocations) which do not require treatment by surgical methods, regardless of the underlying pathology. Excluded "treatment" of the above conditions includes evaluations as well as the nonsurgical measures, supplies, or appliances used to correct the condition or alleviate symptoms. The exclusion does not apply where such treatment is purely incidental to and an integral part of covered foot treatment (such as treatment of a fracture) or where performed as a part of postoperative care during the period of convalescence from covered foot surgery.

This exclusion does not apply to the ankle joint (talo-crural joint).

C. Routine Foot Care.--Routine foot care includes the cutting or removal of corns, warts, or calluses, **the trimming of nails**, and routine hygienic care. "Routine hygienic care" includes hygienic and preventive maintenance care of the feet, of the type which is ordinarily considered self-care, such as observation and cleansing of the feet, use of skin creams to maintain skin tone of both ambulatory and bedfast **patients**, nail care not involving surgery, prevention and reduction of corns, calluses and warts, and any services performed in the absence of localized illness, injury, or symptoms involving the foot.

The above types of "routine" care are excluded regardless of the reason for such care. Thus, the fact that a particular individual is unable to perform certain care for himself (for example, because of a physical disability or a predisposing systemic disease such as diabetes or peripheral vascular disease which makes preventive hygienic foot care particularly important) does not change the character of the services and make them "nonroutine." Hygienic and other care which is simply incident to and an integral part of active covered treatment of foot lesions, such as infections and diabetic ulcers, is not considered as "routine" care and hence is not excluded.

H261.1 Application of Foot Care Exclusions to Provider Services.--- Charges for provider services furnished in connection with non-covered foot care which are normally separately identified by the provider must be shown as noncovered charges. However, the provider need not identify services in connection with noncovered foot care where it is neither the normal practice to separately identify the services nor administratively feasible to establish a separate charge for such services, or where such services are performed only incidentally at the same time as and as a necessary integral part of a primary covered procedure. In addition, where services or procedures are performed in connection with the diagnosis of specific symptoms or complaints which require covered services, the initial diagnostic services are covered services regardless of the resulting diagnosis.

Where a patient who is receiving covered hospital services also receives noncovered foot care services (e.g., routine hygienic foot care included as a regular part of the nursing care) and a separate charge is not made for such services, it would not be necessary to compute and exclude that portion of the hospital's charge which is attributable to the noncovered foot care. If, however, the patient receives inpatient or outpatient hospital services for the purpose of noncovered foot care (e.g., surgical removal of a wart on the foot), all of the hospital services received by the patient can be attributed to noncovered services and hence must be excluded from coverage.

An exception to this latter rule may be made where a doctor of medicine or osteopathy certifies that hospitalization is required for proper medical management of a systemic disease during non-covered foot treatment. In such cases, the inpatient hospital services, including all ancillaries, may be covered even though no payment may be made for the professional services performed by the podiatrist or other physician in connection with the foot care.

It is expected that the foot care exclusions will have greater application to outpatient hospital services than to inpatient services. For example, in the outpatient department it is more likely that the total services received on an occasion can be attributed to noncovered foot care and hence excluded (as in the case of outpatient surgical removal of a wart). In an outpatient situation it is also more likely that separate itemization of charges for noncovered foot care not integrally related to a covered procedure may be the usual practice, thereby permitting exclusion of such charges (as in the case of a separate excludable charge for routine foot care furnished as a hospital service as part of followup visits to a diabetic clinic).

Physician Certification and Recertification

H273. CERTIFICATION AND RECERTIFICATION BY PHYSICIANS--GENERAL
The amendments eliminate the requirement for certification by a physician as to the need for admission in the case of inpatient hospital services as well as the requirement for a physician's certification for outpatient hospital services. (The physician certification requirement is, however, retained for some outpatient services, such as ambulance service.) As under the prior law, the amendments provide that, where inpatient hospital services are furnished over a period of time, a physician's certification as to the need for continued stay would be required, in accordance with criteria to be set forth in regulations. (For purposes of the requirements with regard to the need for continued stay, the amendments use the term "certify" whereas the prior law used the term "recertify.") All other physician certification and recertification requirements have been retained.

The amendments also provide that a doctor of podiatry or surgical chiropody is not a "physician" for physician certification and recertification purposes. (The amendments add to Part B the coverage of nonroutine services of doctors of podiatry or surgical chiropody.) Where covered provider services are furnished to the patient of a podiatrist, the required certification and recertification statement can be prepared only by a physician who is permitted to do so, that is, a doctor of medicine or osteopathy or, in certain circumstances, a doctor of dentistry or of dental or oral surgery.

Except as indicated below, hospitals and other providers of services will continue to obtain physician certification and recertification statements in accordance with existing provider manual instructions.

H274. INPATIENT HOSPITAL SERVICES CERTIFICATION

The requirement for certification as to the need for inpatient admission is eliminated with respect to patients admitted to the hospital on or after January 3, 1968. Where inpatient hospital services are furnished over a period of time, the hospital must obtain statements in accordance with the existing manual instructions on physician recertification (sections 275 and 276). Accordingly, an initial certification statement must be obtained as of the 14th day of hospitalization, a second statement as of the 21st day, and subsequent statements in accordance with intervals established by the hospital utilization review committee, but not exceeding 30 days. (See § H216 for application of the certification provisions to lifetime reserve days.) The certification statements

must contain the same information called for by the existing recertification instructions, that is, the reasons for and estimated period of continued hospitalization and any plans, where appropriate, for posthospital care.

(There is no change in the physician certification and recertification requirements for inpatient psychiatric and tuberculosis hospital services. Thus, psychiatric and tuberculosis hospitals must continue to obtain, in accordance with existing instructions, certification statements as to the need for inpatient admission.)

H280. OUTPATIENT HOSPITAL SERVICES

Physician certification is not required for the following outpatient hospital services furnished on or after January 3, 1968: (a) hospital services and supplies incident to physicians' services rendered to outpatients (see section 240.2), and (b) diagnostic services furnished to outpatients by a hospital or which the hospital arranges to have furnished in other facilities operated by or under the supervision of the hospital or its medical staff (see section 232). (Outpatient hospital diagnostic services will continue to be covered under Part A through March 31, 1968; thereafter, coverage is transferred to Part B. The amendments eliminate the physician certification requirement with respect to both the Part A and Part B coverage of these services.)

It will still be necessary for hospitals to obtain a physician's certification with respect to services furnished to outpatients that are not covered as outpatient hospital therapeutic or diagnostic services under (a) or (b) above. Primarily, this means that a certification statement is needed for diagnostic services furnished under arrangements by a facility that is not operated by or under the supervision of the hospital or its organized medical staff (see sections 232.2 and 232.3), e.g., services obtained from an independent laboratory. For such services, the existing physician certification instructions on medical and other health services furnished by a provider of services will be followed. Certification by a physician in connection with ambulance services furnished by a participating hospital will continue to be required.

Chapter III

ADMISSION PROCEDURES

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300. SUMMARY OF ADMISSION PROCEDURES

The purpose of this section is to give a brief outline of routine handling of admissions. Detailed instructions on procedures as well as descriptions of special situations are given in subsequent sections.

The first step in preparing the Notice of Admission in inpatient cases is to ask the patient for his health insurance card. It is very important that the claim number on this card be accurately recorded on the admission notice since the case cannot be processed if the number is missing or incorrect. If you cannot get the health insurance claim number from the patient, get in touch with the social security district office for help.

The second step is to ask the patient if he was an inpatient in any hospital or extended care facility during the prior 60 days. If he was, ask for additional information about the number of days of hospitalization he has had in the current spell of illness. This will indicate how many days of eligibility remain in this spell of illness. Your intermediary (or the Social Security Administration if you are dealing directly with the Government) will make any necessary additional verification of these prior stays.

The third step is to fill in the other items on the admission form, have the patient sign the form or the hospital's admission record (see §§ 270ff.), and send the information to your intermediary or the social security office if you deal directly.

Your intermediary will check the Social Security Administration central record, then send you a reply giving the patient's remaining days of eligibility and deductible status so that you can prepare the billing form.

In outpatient cases you will go through the same steps of asking for the health insurance card to establish whether the patient is entitled under Part B, and to obtain the correct health insurance claim number. However, you will send the admission information to your intermediary at the same time you forward your billing. (See § 420.1 for completing admission items for outpatient hospital services.)

301. HOSPITAL PREPAYMENT REQUESTS AND REQUIREMENTS

A. General.--Prohibition Against Requiring Prepayment as a Condition of Admission.--Hospitals may not require from a beneficiary (i.e., a person for whom payment is expected under Part A) or from someone on his behalf, advance payment of the Part A inpatient deductible or coinsurance amounts as a condition of admission for inpatient services; nor, in the typical case, may admission be denied for failure to prepay the Part B deductible.

Hospitals may not require a beneficiary, as a condition of his admission, to prepay any Part B charges unless **all** the following conditions are met; and where they are **all** met, no more than the unmet part of the \$50 deductible may be collected:

(1) The hospital regularly requires prepayment from all other patients who have comparable insurance or other protection assuring satisfaction of substantially all hospital charges or costs.

(2) The beneficiary is expected to incur expenses for the services of a salaried physician employed by the hospital and such services are subject to the \$50 deductible and coinsurance provisions of Part B. (Certain radiology and pathology services furnished after March 1968 to an inpatient are not subject to either the deductible or coinsurance.) A hospital cannot deny admission to a beneficiary for failure to prepay physician charges which the hospital is collecting only on behalf of a physician or as a convenience to the physician.

(3) At least one of the following additional conditions is met:

(a) the beneficiary is not enrolled for medical insurance (Part B) coverage and has no equivalent protection; or

(b) the beneficiary does have medical insurance (Part B) protection but has not met his Part B deductible or cannot (upon being asked) submit evidence that he has met the deductible.

B. When Prepayment May Be Requested.--In admitting a beneficiary, hospitals may **request** the deductible or coinsurance amounts only where it appears that the patient will owe such amounts and it is the hospital's routine and customary policy to request similar prepayment from nonbeneficiary patients with hospital insurance (or similar benefits) which leaves them responsible for a small part of the cost of their hospital services. If a beneficiary with Part B coverage shows that he has met the \$50 Part B deductible, the hospital should not request or require prepayment of the deductible. In admitting the patient, such a hospital should ascertain whether he has medical insurance coverage, and where he does, should ask if he has an Explanation of Benefits form showing his deductible status.

Except in the rare cases where prepayment may be required, any request for payment must be made as a request and without undue pressure; the beneficiary (and his family) must not be given cause to fear that admission will be denied for failure to make the advance payment.

Hospitals should insure that all their admitting office personnel are informed and kept fully aware of the hospital's policy on prepayment, which must be consistent with this section. For this purpose, and for the benefit of the hospital and the public, it would be desirable that a notice be posted prominently in the admitting office or lobby of the hospital to the effect that no patient will be refused admission for inability to make an advance payment or deposit, if Medicare is expected to pay for his hospital costs.

C. When Prepayment May Be Required.---With regard to noncovered services (i.e., personal comfort items, a private duty nurse, etc.) a hospital may deny such services for which the beneficiary has not paid or offered satisfactory assurance of payment, if that is the hospital's practice with its nonbeneficiary patients. For example, a hospital need not furnish a private room or TV set to a patient who requests them but is unable to prepay or offer the assurance of payment which the hospital usually requires.

In cases where the aged person has exhausted his covered inpatient hospital benefits, and in cases where an aged applicant cannot supply satisfactory evidence of entitlement under Part A, the hospital is free to apply to such persons its usual policy with respect to requiring prepayment or other assurance of payment where the patient has no insurance. Also, for that small minority of beneficiaries receiving covered inpatient services who are not enrolled for medical insurance (Part B), a hospital is free to apply its usual policy on prepayment or assurance of payment with regard to services of salaried physicians provided by the hospital.

D. Compliance With Agreement.---It is anticipated that most hospitals will conform to the policy set forth in this instruction. Noncompliance will be considered in determining whether the hospital is honoring its agreement, under which the hospital may not charge for services for which payment may be made under the Medicare program.

302. HEALTH INSURANCE CARD

The Social Security Administration maintains in Baltimore, Maryland, the records of all persons entitled to health insurance. After entitlement is established, each beneficiary is issued a health insurance card by the Social Security Administration (or in some cases by the Railroad Retirement Board) for use in obtaining hospital insurance benefits, medical insurance benefits, or both.

The health insurance claim number on the card is essential in locating the patient's record when a claim for benefit payment is made. No admission notice or billing form should be forwarded without the correct claim number. Exhibit 1 of this chapter shows the health insurance cards and briefly explains the numbering system as an aid in recognizing valid numbers.

The hospital should ask each patient who gives his age as 65 or more for his health insurance card to determine his health insurance entitlement status and obtain the correct health insurance claim number. When the hospital knows in advance of an impending stay by a 65 year-old patient, it should advise him to bring his health insurance card when admitted, and suggest that he get in touch with the social security district office if he does not have one. If a patient already in the hospital is within 3 months of age 65 and has not applied for hospital insurance entitlement, it will be helpful if he, or someone on his behalf, is advised to contact the district office. The hospital may wish to arrange with the district office to bring such cases routinely to its attention.

A health insurance card is acceptable without a signature. However, the patient should be asked to sign the card if he has not already done so.

302.1 Certificate of Social Insurance Award or Temporary Eligibility Notice.--An individual who has not yet received his health insurance card may present one of the following to indicate his health insurance entitlement status.

a. **Certificate of Social Insurance Award.**--Health insurance beneficiaries receive a Certificate of Social Insurance Award (see exhibit 1B) showing the health insurance claim number, dates of entitlement to Part A and Part B, and the following statement:

"This notice may be used if medicare services are needed before you receive your health insurance card."

b. **Temporary Eligibility Notice.**--Where there is a need for immediate medical services, the social security district office may issue a temporary health insurance eligibility notice (see exhibit 1C) before a Certificate of Social Insurance Award or health insurance card is issued.

The patient's name and health insurance claim number on these notices should be entered on the admission notice. The intermediary will use this information for checking the Social Security Administration central record and for replying to the hospital about the patient's days of eligibility and deductible status.

304. NOTICE OF HOSPITAL (OR MEDICAL) INSURANCE UTILIZATION OR EXPLANATION OF BENEFITS

If the patient cannot furnish his health insurance card or one of the notices described in § 302.1 when admitted, he may have a utilization form which shows his claim number. Form SSA-1533, Your Record of Hospital Insurance Benefits Used Under Medicare, (see exhibit 2) is mailed to a beneficiary shortly after Part A inpatient hospital, extended care, or home health benefits have been paid on his behalf. Form SSA-1533A, Notice of Medical Insurance Utilization (see exhibit 3) is mailed to a beneficiary after payment of Part B home health benefits. An Explanation of Benefits is sent to a beneficiary by the Part B carrier after payment of a supplementary medical insurance claim. The beneficiary receives a utilization notice after payment on his behalf for Part B inpatient and outpatient hospital and extended care facility services.

These forms, if current, may also indicate to the hospital the patient's remaining eligibility under hospital insurance, or deductible status under supplementary medical insurance. However, an admission notice must always be sent in inpatient cases regardless of the currency of any of these forms.

306. CONTACTS WITH SOCIAL SECURITY DISTRICT OFFICE TO OBTAIN HEALTH INSURANCE CLAIM NUMBERS

When a patient cannot furnish the health insurance claim number, the hospital may request it from the social security district office. Ordinarily, the social security office will have arranged with the hospital for handling these requests. If not, the hospital should get in touch with the office to make such arrangements.

The social security office can also help a beneficiary replace a lost or destroyed health insurance card.

306.1 Information Required by Social Security District Offices.---

If the patient's social security account number is available, the district office usually requires no additional information to locate the health insurance claim number or to determine that the patient has not established health insurance entitlement.

If the patient has ever been employed or self-employed, or sought employment, or filed Federal income tax returns, he should have a social security card. This card contains his social security account number which consists of 9 digits, 000-00-0000, but does not have the letter prefix or suffix which distinguishes the health insurance claim number. (See exhibit 1.)

A social security account number without a letter prefix or suffix is not sufficient for processing a claim.

If the account number is not available, the following information should be furnished.

- a. The patient's name and statement as to whether or not he ever applied for social security monthly benefits, railroad retirement benefits, or for hospital insurance benefits;
- b. If the patient says he applied, the name of the person on whose social security account the application was based, e.g., his own account or the account of a husband or a wife;
- c. The full name of the patient's father, the maiden name of the patient's mother, and the patient's date and place of birth;
- d. Patient's address.

If the hospital cannot give all the identifying information required from the beneficiary, it should furnish as much as it has to the social security district office.

306.2 The Social Security District Office Reply.--The social security office will furnish the health insurance claim number as soon as possible. If the claim number is not available, the office will inform the hospital of the action it is taking, i.e., that a claim number has been requested from SSA central records, that it is developing an application, or that an application is pending.

If an application for hospital insurance benefits is taken as a result of the request to the district office for a claim number, or is pending when the hospital requests a claim number, the office will give the hospital the claim number when processing is completed. The hospital may then send the notice of admission information to the intermediary (or to the district office if the hospital deals directly with SSA).

308. HOSPITAL ADMISSION WHERE A HEALTH INSURANCE CLAIM NUMBER IS NOT AVAILABLE AND PATIENT'S CONDITION IS CRITICAL OR DISCHARGE IS NEAR

Occasionally a patient age 65 or older is admitted to a hospital in critical condition, a health insurance claim number is not available, and there is some question whether he has established health insurance entitlement. The normal procedures of contacting the social security office may not afford sufficient protection of the individual's benefit rights. In such cases, the hospital should have a Form SSA-18, Application for Hospital Insurance (or a comparable protective statement, see below) completed on the patient's behalf by an interested person, e.g., a relative who may be available.

If no interested person is available, the hospital administrator or his designee may complete the application. Only as much of the identifying information required in Items 1 through 5 on the form as is readily available should be completed. It is imperative, however, that the form show the patient's name and that it be signed.

The procedure may also be used where the patient is to be discharged shortly and his claim number is unavailable. In this situation, the application (or statement) may be completed either by the patient or by someone on his behalf if he is unable to do so.

The number of instances when this procedure will be used will be quite limited. Supplies of form SSA-18 will be made available by the social security district office. Larger hospitals will wish to obtain a small supply. Smaller hospitals, however, may find it preferable to prepare a statement to be signed by the interested party which reads as follows:

"I hereby apply on behalf of _____
_____ for all benefits payable under the Social
Security Act."

The application or statement must be completed while the patient is alive. It is effective upon receipt by the Social Security Administration. Therefore, it should be submitted or mailed to the social security office on the same day it is executed. When it is mailed, the postmark date will serve to establish the effective filing date with SSA. The social security office will get in touch with the individual to obtain any additional information necessary to complete the application.

In the situations discussed above, a request for health insurance payment executed in accordance with § 271 would be appropriate.

309. INTERMEDIARY REQUESTS TO VERIFY PATIENT'S HEALTH INSURANCE CLAIM NUMBER

Where the name and claim number information on a notice of admission does not match the central record, the intermediary will request the hospital to verify the information. (In outpatient cases, the intermediary will verify the information on the outpatient billing form either with the hospital or the social security office.)

The hospital should first verify the name and number on the admission notice with the patient if he is still in the hospital, or, if he has been discharged, check its records. If the information submitted was incorrect, the hospital should send the corrected information to the intermediary.

If, however, the hospital finds that its information identifying the patient is the same as the information already submitted on the notice of admission (or outpatient billing form), it should contact the social security office for assistance. The hospital should inform that office that an admission notice was rejected because the name or number submitted did not match the Social Security Administration central record.

After investigation, the social security office will furnish the hospital with the correct name or number, or will confirm that the individual is not entitled to health insurance. The hospital should report this information to the intermediary.

310. NOTICE OF ADMISSION

When a patient 65 years or older is being admitted to the hospital for inpatient services, the hospital will complete the admission part (see exhibit 4) of the Inpatient Hospital and Extended Care Admission and Billing form (SSA-1453). The Inpatient Hospital and Extended Care Admission and Billing may be used by general hospitals, psychiatric hospitals, and tuberculosis hospitals. The bottom two copies of this form are the admission copies. The top copies are retained for billing purposes, while the bottom copies may be detached and used in furnishing admission information to the intermediary. If you report admissions by other means, the admission copies may be destroyed.

Upon completion of the form furnish the notice of admission information to the intermediary (or to the appropriate Social Security Administration district office if the hospital deals with SSA). The information may be forwarded by mail, messenger, or telephone depending on the arrangements with the intermediary or the district office.

The admission notice should not be forwarded before the first date a patient is actually entitled to hospital insurance benefits. If a patient enters the hospital before the month he becomes age 65, the admission notice should not be sent before the first day of the month in which he becomes 65.

310.1 Completing Inpatient Hospital and Extended Care Facility Notice of Admission, Form SSA-1453. --Use a typewriter or legible printing for all entries on the form.

Item 1: Patient's Name.--Enter the patient's last name, first name, and middle initial from his health insurance card or other notice. (See § 302.)

1. Patient's last name Public	First name John	MI Q.
----------------------------------	--------------------	----------

Item 2: Sex.--Enter "X" in the appropriate block.

2. Sex
<input checked="" type="checkbox"/> M <input type="checkbox"/> F

Item 3: Health Insurance Claim Number.--Enter the patient's health insurance claim number as shown on his health insurance card, certificate of award, utilization notice, temporary eligibility notice, or as reported by the social security office. (See §§ 302-306.)

3. Health insurance claim number 000-00-0000A
--

Item 4: Patient's Address.--Show the patient's mailing address from your records. Where the patient's authorized representative is applying on behalf of the patient, show the authorized representative's name and address.

4. Patient's address (Street number, City, State, ZIP Code) 123 Anyplace Blvd., Baltimore, Maryland 21235
--

Item 5: Date of Birth.--Enter the patient's date of birth by month, day and year in 6-digit numbers. If the date of birth is unknown, transmit the notice of admission without the date of birth. If only the year of birth is known, show the year. While the date of birth is useful as identification and should be shown when available, an admission notice will be processed without it.

5. Date of birth 09:09:99

Item 6: Medical Record Number.--Make an entry only if the hospital assigns such numbers for its own filing purposes.

6. Medical record number P30861

Item 7: Date of This Admission

General Hospitals.--Enter the date of this admission. This means the actual date of admission, even where the effective date of entitlement is a later date. For example, where a patient entered a hospital on March 25, 1968, and is entitled to hospital insurance on April 1, 1968, enter the actual admission date 03/25/68. Do not forward the Notice of Admission before the patient's entitlement date of April 1, 1968.

7. Date of this admission					
0	3	2	5	6	8

Psychiatric and Tuberculosis Hospitals.--Enter the date the patient was admitted for active treatment or a medically necessary inpatient diagnostic study. This will be the day on which the patient is admitted to the hospital or qualifying distinct part of a psychiatric or tuberculosis hospital even where the actual treatment or diagnostic procedures did not begin until a later date.

Items 8 & 9: Hospital Identification.--Enter the name, city, and State of the hospital and the hospital's assigned health insurance provider number. Abbreviations should be used. This information may be preprinted on all copies of the hospital's supply of these forms.

8. Provider name and address (City and State)	9. Provider number
General Hospital, Balt., Md. 21201	000000

Item 10: Attending Physician.--Enter the initials and last name of the attending physician.

10. Attending physician
W. E. Jones

Item 11: Dates of Qualifying Stay.--Hospitals will **not** use this item. It is intended for the use of the extended care facilities to indicate that the 3-day hospitalization requirement is met.

11. Dates of qualifying stay					
FROM					
__	__	__	__	__	__
THRU					
__	__	__	__	__	__

Item 12: Qualifying and Other Prior-Stay Information.--Enter first the name and address of any hospital (including your own), extended care facility, or nursing home from which the patient says he was discharged as an inpatient within the last 60 days, whether or not the institution is participating under medicare. If the prior stay was in your hospital, enter "SAME" and the dates of the prior stay. Psychiatric or tuberculosis hospitals preparing this form for a patient who was in the part of the hospital which does not participate as a psychiatric or tuberculosis hospital should show "SAME--stay before admission to participating part from (date) to (date)."

A recent prior admission or discharge may indicate whether the patient has limited or no eligibility in the current spell of illness, whether the \$40 inpatient or blood deductibles apply to this hospital stay, or whether one or both of the coinsurance provisions will be in effect.

Part A inpatient benefits, except for the lifetime reserve days, are related to a spell of illness, and once begun a spell of illness cannot end until an individual has not been an inpatient of a hospital, extended care facility, or certain nursing homes for 60 consecutive days beginning with the day of last discharge. An inpatient stay in a hospital, extended care facility, including a skilled nursing home, continues a spell of illness and prevents the start of a new spell of illness with the current admission. (See § 215.)

The information furnished by the hospital on the admission notice will be checked against the patient's central record and the intermediary's record. If further investigation is necessary, e.g., the date of prior discharge is not recorded on the patient's utilization record, or the prior-stay institution was a nonparticipating provider, the intermediary will verify the prior dates of stay.

If applicable, psychiatric hospitals who are billing for the first day the patient became entitled to hospital insurance will enter the name and address of any psychiatric hospital which furnished inpatient services in the 150-day period preceding the patient's effective date for hospital insurance entitlement. The effective date of the patient's entitlement to hospital insurance is shown on his health insurance card. If the institution named is your own hospital, show "SAME from (date) to (date)." Show only the dates during which the patient was in the participating part of the institution.

12. Qualifying and other prior stay information

General Hospital
100 Bruce Street
Baltimore, Md. 21201

Items 13 & 14: Complementary Coverage Information.--If the patient requests, and the hospital does not object, that information about the claim be forwarded to a complementary insurer, such as a private health insurance plan or a welfare agency, enter the name and address of the organization in item 13 and the patient's identifying number in item 14.

If you have other health insurance or if your State Medical Assistance Agency will pay part of your medical expenses and you want information about this claim released to them upon their request, complete items 13 and 14.

13. Insuring organization or State agency name and address

Anyplace City Dept. of Welfare, 25 Howard St., Anyplace, Md. 21201

14. Policy or medical assistance no.
34682B

Item 15: Patient's Certification, Authorization to Release Information and Payment Request.--Have the patient or his authorized representative read the statement on the form or the statement in the hospital admission record if the hospital uses the alternate signature procedure (see §§ 270 ff.). If the hospital obtains the signature on its own form, check the block marked "Contained in Provider's Record." If the signature is obtained on form SSA-1453, it is sufficient if it is legible only on the original copy of the form.

15. Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related medicare claim. I request that payment of authorized benefits be made on my behalf.

<input checked="" type="checkbox"/> Contained in provider's record	Signature (Patient or authorized representative) (Signature by mark must be witnessed)	Date
--	--	------

If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf; e.g., John J. Jones by Jack A. Smith. In certain situations, a hospital representative may sign on behalf of the patient. (See § 271 for who may file a payment request.)

Briefly explain why the patient himself did not sign the form and show the relationship of the signer to the patient. Retain the explanation in the hospital's file if the signature is obtained on the hospital's own record. If the signature is on form SSA-1453, the explanation should accompany or be included on the billing form.

The statement should be read to a patient who signs by mark. A signature by mark should be witnessed by a person who knows the patient. Enter the name and address of any person witnessing a signature by mark.

15. Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related medicare claim. I request that payment of authorized benefits be made on my behalf.

<input type="checkbox"/> Contained in provider's record	Signature (Patient or authorized representative) (Signature by mark must be witnessed) (X) MARY Jones - 2500 Hopson St., Anyplace, Md.	Date 4/30/68
---	---	-----------------

Item 16: Admitting Diagnosis.--Enter the admitting diagnosis as furnished by the physician. List the primary condition first. If the condition is considered to be employment related, show the name and address of the employer. (See §§ 289 ff. for effects of workmen's compensation involvement.)

16. Admitting diagnoses (If employment related, also give name and address of employer)

Cardiovascular Accident

315. CONTENTS OF INTERMEDIARY REPLY TO NOTICE OF ADMISSION

The reply to the notice of admission will be furnished by the intermediary to the hospital according to prior arrangements. If the hospital deals directly with the Social Security Administration, it will receive a form reply to the notice of admission from the Bureau of Health Insurance, Direct Reimbursement. The contents of the reply will be based on the intermediary's query to SSA central record for eligibility information and any necessary investigation of prior inpatient stays.

The Report of Eligibility part of the SSA-1453 (lower portion of the bottom two copies) may be used as a reply to the admission notice, where it is received by the intermediary as part of the admission notice. Whether the reply is given by telephone, mail, or wire to the hospital, it contains eligibility information similar to the content of the Report of Eligibility part of the admission notice. An explanation of the eligibility information in the Report of Eligibility is outlined below:

A. Effective Date--Hospital Insurance. The month, day, and year of the patient's entitlement to hospital insurance benefits (Part A) will be shown. If not entitled, the entry will so indicate.

B. Effective Date--Medical Insurance. This will show the month, day, and year of the patient's entitlement to medical insurance (Part B). The entry will so indicate if the patient is not entitled to Part B benefits. The patient should be billed for the professional component charges when he is not entitled to Part B. This should be done even where the hospital uses the combined billing method for pathology and radiology.

C. Hospital Days Remaining. The number of inpatient days for which payment can be made in full will be shown in the "FULL" block. The number of spell of illness inpatient days for which the patient is responsible for \$10 coinsurance payments will be shown in the "COINSURANCE" block.

D. Lifetime Reserve Days Remaining. The number of lifetime reserve days for which the patient is responsible for \$20 coinsurance payments will be shown here.

E. Medical Plan Deductible. The status of this deductible will be indicated by a checkmark in the block designated "MET" or "NOT MET." If the deductible is not met, the amount remaining to be met will not be shown.

F. Remaining Inpatient Deductible. The dollar amount of the \$40 inpatient deductible yet to be met for the current spell of illness will be shown. Where it has been met, "NONE" will be entered.

G. Pints Remaining--Blood Deductible. This will show the number of pints of whole blood or packed cells needed to satisfy the Part A blood deductible for the current spell of illness. Where applicable, "NONE" will be shown.

H. ECF Days Remaining. The number of extended care facility days for which payment can be made in full for the current spell of illness will be shown in the "Full" block. The number of days remaining for which the patient must pay the coinsurance amount, will be shown in the "Coinsurance" block. "NONE" will be shown where applicable.

I. 3-Day Hospital Stay Requirement. In replying to notices of admission to ECF's, the intermediary will complete this item to show whether these requirements are "MET" or "NOT MET."

J. 14-Day Transfer Requirement. (See "I" above.)

K. HHA Visits Remaining--Hospital Insurance and Medical Insurance. For informational purposes the number of home health visits remaining for the hospital insurance will be shown. Medical insurance visits remaining will not be routinely shown in replying to hospital notices of admission.

L. Psychiatric Days Remaining. This information will be shown where the admitting hospital is a psychiatric hospital. It will show the number of days remaining toward the 190-day lifetime limitation on inpatient psychiatric services.

M. Open-Item Information. The information in this block will be completed by the intermediary when verifying reports of open items (admissions recorded in SSA central records, but not closed out by processing of a bill).

Where there is an open item reported from the SSA central record to the intermediary or Bureau of Health Insurance, Direct Reimbursement, either the intermediary or Direct Reimbursement will contact the "open-item" provider to verify the stay, the date of the prior discharge, and status of the bill. The intermediary will use this information in computing the remaining days of eligibility.

Remarks. Any necessary explanation of eligibility information will be shown. This will include corrections in the name or health insurance claim number the hospital reported. When changes of this sort are shown, the name and claim number information on the billing form should be changed accordingly.

If name and claim number information did not match, the intermediary will request the hospital to verify. See § 309 for the action to be taken by the hospital.

The hospital may also be requested to verify reports of death shown in the patient's central record.

320. RETROACTIVE ENTITLEMENT

When an application for social security benefits is filed by a person over 65 years of age, he may inform the social security office that he received hospital services in the retroactive period of up to 12 months for which he may be entitled to benefits. Payment for the hospital services received in this period is possible (see § 120). The social security office will tell the individual to get in touch with the hospital. In these cases, follow the notice of admission

procedure to obtain a report of eligibility from your intermediary before billing. If the patient had paid the hospital, the hospital should refund the appropriate amount.

325. INITIATING NOTICES OF ADMISSION WHERE NO PAYMENT WILL BE MADE
Section 450 explains that hospitals are to submit inpatient billing forms even when benefits are exhausted or are not payable for some other reason. In most such cases, notices of admission will have been initiated as a normal course of hospital procedure to determine the patient's eligibility. However, there will be some situations where, at admission, the individual tells you that benefits have been exhausted in the current spell of illness, or he presents a Form SSA-1533, Your Record of Hospital Benefits Used Under Medicare, which indicates this. The hospital should nevertheless initiate a notice of admission. This notice will serve to verify the information and assure that the patient has in fact no remaining eligibility.

The notice of admission is also essential for processing the billing form to be submitted in accordance with § 450.

Notices of admission should also be initiated where no payments can be made because of the following: workmen's compensation paid or can be expected to pay the entire bill; services are not covered; the inpatient psychiatric restriction (§ H217) reduces the inpatient psychiatric days available to none; the inpatient psychiatric and tuberculosis restriction (§ 217) fully reduces the inpatient benefit days available from 90 to none; payment will be made by a National Institutes of Health grant; or, the patient refused to request payment.

Where the patient refuses to request payment and does not furnish his health insurance claim number, the hospital should attempt to get the claim number from the social security office. (See § 306.1 for the information that office needs to locate the claim number.)

330. NOTICES OF ADMISSION FOR EMERGENCY SERVICES IN NONPARTICIPATING HOSPITALS

Nonparticipating hospitals will use Form SSA-1453, Inpatient Hospital and Extended Care Admission and Billing as a notice of admission and to bill for covered emergency services where the hospital has elected to bill the program. (Use Form SSA-1483, Provider Billing for Medical and Other Health Services for emergency outpatient services.) Where a patient is admitted and the hospital has elected to bill the program for all emergency services, the admission portion of form SSA-1453 should be completed and the bottom

two copies detached and sent to the social security district office. Items 1 through 16 of the form are to be completed according to § 310.1. The words "Emergency Admission" should be typed or printed with a ball-point pen in item 13 of the form.

The district office will transmit the admission notice to the Social Security Administration central records. (If the hospital has not been assigned an identification number as a provider qualified to furnish emergency services, the district office will request the SSA regional office to determine the hospital's status and assign an emergency provider number if it qualifies.) A reply to the admission notice giving the patient's eligibility status will be forwarded to the hospital by the SSA district office.

When claiming payment, the hospital completes the remainder of form SSA-1453 and sends it with a copy of the eligibility reply and supporting documentation (see §§ 202 ff.), to the SSA district office.

Where the hospital has not elected to bill the program, the hospital should issue the patient an itemized bill and direct him to file his claim through the SSA district office.

399. EXHIBITS

Exhibit 1A. Health Insurance Cards and Claim Numbers.

Exhibit 1B. Certificate of Social Insurance Award.

Exhibit 1C. Temporary Notice of Eligibility.

Exhibit 2. Your Record of Hospital Insurance Benefits Used Under Medicare (Form SSA-1533).

Exhibit 3. Notice of Medical Insurance Utilization (Form SSA-1533A).

Exhibit 4. Inpatient Hospital and Extended Care Admission and Billing (Admission Copy)--Form SSA-1453.

HEALTH INSURANCE CARDS

Health Insurance	
SOCIAL SECURITY ACT	
NAME OF BENEFICIARY JANE Q. DOE	
CLAIM NUMBER 000-00-0000B	SEX FEMALE
IS ENTITLED TO HOSPITAL INSURANCE 7-1-66 MEDICAL INSURANCE 7-1-66	
SIGN HERE <input type="checkbox"/>	

Front

Health Insurance	
RAILROAD RETIREMENT BOARD	
NAME OF BENEFICIARY JOHN C. DOE	
CLAIM NUMBER A-000-00-0000	SEX MALE
IS ENTITLED TO HOSPITAL INSURANCE 7-1-66 MEDICAL INSURANCE 7-1-66	
SIGN HERE <input type="checkbox"/>	

Front

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical or health services under "Medicare."
3. Get in touch with your social security office if you have questions about your rights under "Medicare."
4. Your card is good wherever you live in the United States.

WARNING: Issued for the sole use of the holder designated hereon. Intentional misuse of this card is unlawful and will make the offender liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT.
IF FOUND DROP IN NEAREST U.S. MAIL BOX.

Return To: SOCIAL SECURITY ADMINISTRATION
Baltimore, Maryland 21235

FORM SSA-1966 (7-66)

Back

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical or health services under "Medicare"
3. Get in touch with your Railroad Retirement Board office if you have questions about your rights under "Medicare."
4. Your card is good wherever you live in the United States. For benefits in Canada, write to the Railroad Retirement Board.

WARNING: Issued for the sole use of the holder designated hereon. Intentional misuse of this card is unlawful and will make the offender liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT.
IF FOUND DROP IN NEAREST U.S. MAIL BOX.

Return to: RAILROAD RETIREMENT BOARD
844 Rush Street, Chicago, Illinois 60611

Form G-43 (2-66)

Back

HEALTH INSURANCE CLAIM NUMBERS

Most HI claim numbers are 9 digits with a letter or letter and numeral suffix; e.g., 000-00-0000B or B1. They may also be 6-or-9-digit numbers with lettered prefixes; e.g., A000000, A-000-00-0000; or WD-000000, WD-000-00-0000. Numbers with one or more letter prefixes identify Railroad Retirement Board annuitants.

Possible suffixes are:

A, B, B1, B2, B3, B4, B5, B6, or B9

C1, C2, C3, C4, C5, C6, C7, C8, or C9

D, D1, D2, D3, D4, D5, D6, or D7

E, E1, E2, or E3

F1, F2, F3, F4, F5, F6, F7, or F8

HB, HB1, HB2, HB3, HB4, HB5, HB6, or HB9

HC1, HC2, HC3, HC4, HC5, HC6, HC7, HC8, or HC9

J1, J2, J3, J4 (For subscripts "3" and "4" there can be no entitlement to hospital insurance benefits.)

K1, K2, K3, K4 (Supplementary medical insurance entitlement may exist for all J and K suffixes.)

M, M1, and T (Suffix letter "T" indicates entitlement to hospital or hospital and medical insurance; letters M and M1 indicate that the patient is eligible for supplementary medical insurance benefits but not for hospital insurance benefits.)

When the status of a beneficiary changes, it is possible for the suffix of his claim number to change.

DISTRICT OFFICE

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

CLAIM NUMBER

Certificate of Social Insurance Award

PAYMENT CENTER:

DATE:



THIS IS TO CERTIFY THAT THE PERSON(S) NAMED BELOW BECAME ENTITLED TO THE INSURANCE BENEFITS SHOWN,
PAYABLE UNDER TITLE II OF THE SOCIAL SECURITY ACT.

NAME AND ADDRESS OF PAYEE AS THE CLAIMANT
OR AS REPRESENTATIVE OF THE CLAIMANT

DATE OF
ENTITLEMENT

MONTHLY
BENEFIT

AMOUNT OF
FIRST CHECK

TYPE OF BENEFIT:

The right to receive social security benefits carries with it certain responsibilities. They are explained in the enclosed booklet. Read this booklet carefully. Be sure that you understand clearly what you can expect by way of benefits, and what is to be expected of you.

NOTICE: If you believe that this determination is not correct, you may request that your case be reexamined. If you want this reconsideration, you must request it not later than 6 months from the date of this notice. You may make any such request through your social security office. If additional evidence is available, you should submit it with your request.

ROBERT M. BALL
COMMISSIONER OF SOCIAL SECURITY

EXHIBIT 1-C

TEMPORARY NOTICE OF ELIGIBILITY

District Office Address:

Date:

Dear :

Based on the information you have given to the Social Security Administration you will be eligible for hospital insurance benefits beginning (mo.) (yr.) and for supplementary medical insurance benefits beginning (mo.) (yr.). Your eligibility will continue for 60 days from the date shown at the top of this notice unless you are notified otherwise during the 60-day period.

To obtain medical services before you receive your card, show this letter to your hospital or doctor but keep the letter with you. This temporary notice of eligibility is to be used only by the person to whom it is addressed. Misuse is unlawful and will make the offender liable to a penalty.

This letter should be destroyed as soon as you receive your health insurance card or other notice concerning your eligibility.

Sincerely yours,

Robert M. Ball
Commissioner of Social Security

IMPORTANT

When services are provided on the basis of this notice, all bills or correspondence with an intermediary or the Social Security Administration should show the patient's social security claim number.

EXHIBIT 2

Your Record of Hospital Insurance Benefits Used Under Medicare, SSA-1533



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

d

YOUR RECORD OF HOSPITAL INSURANCE BENEFITS USED UNDER MEDICARE

(THIS IS NOT A BILL)

┌

┐

DATE:

YOUR CLAIM NUMBER:

└

┘

In any correspondence, please refer to this number.

Dear Beneficiary:

Recently, your Medicare Hospital Insurance helped pay for the services described below. We are pleased that your social security program was able to assist you.

1. OUR RECORDS SHOW THAT YOU RECEIVED THESE SERVICES

SERVICES WERE PROVIDED BY

TYPE OF SERVICES

WHEN

TO

Your Medicare Hospital Insurance has paid the cost of all COVERED SERVICES except:

For information about any services NOT COVERED by your Medicare Hospital Insurance, please see other side.

If you have any questions about this record, please get in touch with: ▶

2. OUR RECORDS NOW SHOW THESE BENEFIT TOTALS

USED THIS TIME

TOTAL USED

AVAILABLE TO USE FOR
THIS "SPELL OF ILLNESS"
(See "D" on other side.)

INPATIENT HOSPITAL DAYS _____

EXTENDED CARE FACILITY DAYS _____

HOME HEALTH VISITS _____

▶ If you again use services which are covered by your Medicare Hospital Insurance, please show this Record and your Health Insurance Card to the organization providing services.
SEE OTHER SIDE FOR ADDITIONAL INFORMATION.

Sincerely yours,
Robert M. Ball

Robert M. Ball
Commissioner of Social Security

FORM SSA-1533 (8-67)

DATA/GO FORM, INC., MINNEAPOLIS, MINN. 55408 44321

EXHIBIT 3

NOTICE OF MEDICAL INSURANCE UTILIZATION, SSA-1533A

FORM SSA-1533A (6-66)



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

NOTICE OF MEDICAL INSURANCE UTILIZATION

NAME AND ADDRESS OF THE BENEFICIARY
OR REPRESENTATIVE OF THE BENEFICIARY

DATE:

HEALTH INSURANCE CLAIM NUMBER:

The bill for MEDICAL INSURANCE services described below was recently submitted under your health insurance claim number and recorded to your account.

TYPE OF SERVICES	DATES COVERED BY BILL		NUMBER OF HOME HEALTH VISITS INCLUDED
	FROM	TO	

Institution or agency
furnishing services }

Office which handled
your claim }

Each year, as soon as your covered medical expenses go over \$50, your MEDICAL INSURANCE will pay 80 percent of the reasonable costs or charges for all additional covered services for the rest of the year. The computation of MEDICAL INSURANCE benefits for this bill is shown below.

TOTAL COVERED CHARGES	AMOUNT TOWARD \$50 DEDUCTIBLE	20% PAYABLE BY BENEFICIARY	TOTAL PAYABLE BY BENEFICIARY

STATUS OF MEDICAL INSURANCE RECORD

As of the date of this notice, the status of your MEDICAL INSURANCE record is as follows:

Robert M. Ball

Robert M. Ball
Commissioner of Social Security

PLEASE READ THE OTHER SIDE OF THIS NOTICE FOR IMPORTANT INFORMATION.

EXHIBIT 4

Inpatient Hospital and Extended Care Admission and Billing, SSA-1453

INPATIENT HOSPITAL AND EXTENDED CARE ADMISSION AND BILLING HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT						Form Approved Budget Bureau No. 72-R0734	
1. Patient's last name		First name		MI	2. Sex <input type="checkbox"/> M <input type="checkbox"/> F		3. Health insurance claim number
4. Patient's address (Street number, City, State, ZIP Code)					5. Date of birth		6. Medical record number
7. Date of this admission		8. Provider name and address (City and State)			9. Provider number		10. Attending physician
11. Dates of qualifying stay FROM _____ THRU _____		12. Qualifying and other prior stay information					
<p>If you have other health insurance or if your State Medical Assistance Agency will pay part of your medical expenses and you want information about this claim released to them upon their request, complete items 13 and 14.</p>							
13. Insuring organization or State agency name and address						14. Policy or medical assistance no.	
<p>15. Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related medicare claim. I request that payment of authorized benefits be made on my behalf.</p>							
<input type="checkbox"/> Contained in provider's record		Signature (Patient or authorized representative) (Signature by mark must be witnessed)					Date
16. Admitting diagnoses (If employment related, also give name and address of employer)				Do not use this space	17. Discharge or current diagnoses (a) Primary (b) Secondary		Do not use this space

REPORT OF ELIGIBILITY			
A. Effective date – Hospital Insurance			M. Open item information 1. Intermediary
B. Effective date – Medical Insurance			
C. Hospital days remaining	Full	Coinsurance	
D. Lifetime reserve days remaining			
E. Medical Plan deductible	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	2. Provider
F. Remaining inpatient deductible			
G. Pints remaining blood deductible			
H. ECF days remaining	Full	Coinsurance	3. Date admitted
I. 3 day hospital stay requirement	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	
J. 14 days transfer requirement	<input type="checkbox"/> Met	<input type="checkbox"/> Not Met	
K. HHA visits remaining	Hospital Insurance	Medical Insurance	4. Date discharged
L. Psychiatric days remaining			
REMARKS:			
Intermediary approval			Date

FORM SSA-1453 (1-68)

ADMISSION COPY

Department of Health, Education, and Welfare
Social Security Administration

Chapter IV

BILLING PROCEDURES

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400. BILLING PROCEDURES--GENERAL

The forms used by hospitals for billing are:

SSA-1453 (1/68)--Inpatient Hospital and Extended Care Admission and Billing, is used to bill for inpatient services in a participating hospital (general, tuberculosis, or psychiatric) and for emergency inpatient services in a nonparticipating emergency hospital. This form will be used for billings prepared after March 31, 1968.

SSA-1483 (1/68)--Provider Billing for Medical and Other Health Services, is used to bill for Part B services payable on a reasonable-cost basis in a participating hospital; i.e., outpatient services and certain inpatient ancillary services when no Part A benefits are payable. It is also used by a nonparticipating emergency hospital to bill for emergency outpatient services and nonemergency inpatient and outpatient services. This form should be used for Part B services furnished on or after April 1, 1968.

SSA-1554--Provider Billing for Patient Services by Physicians, is used if the hospital is authorized by a physician to bill on his behalf, and the combined billing method is not used.

SSA-1484--Explanation of Accommodation Furnished, is used if an accommodation other than two, three, or four beds was furnished.

If a hospital maintains a home health services department, billing for the services is made on SSA-1487, Home Health Agency Report and Billing. If a hospital maintains a wing that qualifies as an extended care facility, billings prepared after March 31, 1968, will be on SSA-1453 (1/68), Inpatient Hospital and Extended Care Admission and Billing. Instructions for completing the SSA-1487 are given in the Home Health Agency Manual. Instructions for completing the SSA-1453 as it pertains to extended care facilities are given in the Extended Care Facility Manual.

Combined Billing Method.--Under certain conditions, the hospital may be paid for patient services by hospital-based physicians on the basis of the total covered charges shown on the SSA-1453 and SSA-1483.

No SSA-1554 should be prepared for pathologists' or radiologists' services furnished to inpatients receiving Part A services after March 31, 1968, when the hospital and these physicians agree that the charges need not generally be broken down on a bill-by-bill

basis into the Part A and Part B components. However, the professional component charges must be determined in the following situations:

1. The patient is not enrolled under Part B. (The hospital is informed of this in the Reply to the Notice of Admission.)

2. The total covered charges, excluding the professional component, are less than \$40 and the patient has not met the inpatient deductible in the spell of illness. (The Reply to the Notice of Admission indicates the patient's inpatient deductible status.)

3. Part B ancillary services are furnished after Part A benefits are exhausted or are otherwise not payable.

If the combined billing method is used for inpatient services covered under Part A, it should also be used for inpatient services covered under Part B. The combined billing method does not apply to any inpatient services except those furnished by pathologists and radiologists. The combined billing method may be used only where the hospital customarily bills for the hospital's and physicians' services to all patients.

Similarly, no SSA-1554 should be prepared in connection with an SSA-1483 billing where the Part B hospital and professional component charges are not broken down on a bill-by-bill basis. All hospital-based physicians rendering services to outpatients, except for those treating mental diseases, must agree to this method or it cannot be used. An SSA-1554 must be prepared in connection with Part B hospital services rendered to inpatients, unless the services are for pathology and radiology and no SSA-1554 is prepared when Part A benefits are payable. (See § 430 for an additional discussion of hospital billings for physicians' services.)

Inpatient Admission After Outpatient Services.--Sometimes a patient is admitted to the hospital as an inpatient after receiving outpatient services. If the patient is admitted as an inpatient before midnight of the day after the day outpatient services were rendered, all services are considered inpatient services for billing purposes. The day of formal admission as an inpatient will be considered as the first day of inpatient hospital services.

Charges Not Exceeding Deductibles.--A billing form should be submitted even where the patient is responsible for a deductible which covers the entire amount of the hospital charges. This is

required both for inpatient (Part A and Part B) and outpatient services.

Leave of Absence.--It is not necessary to submit a new admission and billing each time the patient has a leave of absence. Instead, the hospital may bill for covered days, excluding leave of absence, using the procedure described under item 27, Leave Days, and item 28, Covered Days, of the SSA-1453.

Repeated Admissions and Discharges.--Sometimes the patient's condition requires that he return at regular intervals to the hospital; e.g., he must be readmitted each week for blood transfusions. This case can be handled as a leave of absence. This procedure should only be used where admissions are predictable on a recurring basis and where there is a brief interval between discharge and readmission. The procedure for billing these cases is described under item 28, Covered Days.

Part B Entitlement Only.--Do not submit an SSA-1453 where the patient has Part B only, even if an admission was previously forwarded. Instead, prepare an SSA-1483 for the covered ancillary services.

INPATIENT HOSPITAL AND EXTENDED CARE ADMISSION AND BILLING

HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

Form Approved
Budget Bureau No.
72-R0734

1. Patient's last name		First name		MI	2. Sex <input type="checkbox"/> M <input type="checkbox"/> F		3. Health insurance claim number	
4. Patient's address (Street number, City, State, ZIP Code)						5. Date of birth		6. Medical record number
7. Date of this admission		8. Provider name and address (City and State)				9. Provider number		10. Attending physician
11. Dates of qualifying stay FROM		12. Qualifying and other prior stay information						
THRU								
If you have other health insurance or if your State Medical Assistance Agency will pay part of your medical expenses and you want information about this claim released to them upon their request, complete items 13 and 14.								
13. Insuring organization or State agency name and address						14. Policy or medical assistance no.		
15. Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related medicare claim. I request that payment of authorized benefits be made on my behalf.								
<input type="checkbox"/> Contained in provider's record		Signature (Patient or authorized representative) (Signature by mark must be witnessed)						Date
16. Admitting diagnoses (If employment related, also give name and address of employer)				Do not use this space		17. Discharge or current diagnoses		Do not use this space
						(a) Primary		
18. Surgical procedures (Show date of each)				Do not use this space		(b) Secondary		Do not use this space
19. STATEMENT OF SERVICES RENDERED								
Blood pints furnished	Pints replaced	Not replaced	Charge per pint	Total Charges	Non-covered Chg's.			
A.								
Accommodation		Days	Rate					
B. 1-Bed								
C. 2-3-4 Bed								
D. 5 or more Beds								
FOR HOSPITAL ONLY	E. Intensive care							
	F. Self care							
	G. PIP total							
	H. Operating room							
	I. Anesthesia							
J. Outpatient services								
K. Blood administration								
L. Pharmacy								
M. Radiology								
N. Laboratory								
O. Medical, surgical and central supplies								
P. Physical therapy								
Q. Occupational therapy								
R. Speech therapy								
S. Inhalation therapy								
T. Other (Describe)								
U. TOTALS								
V. Inpatient deductible								
W. Blood deductible		pts. @						
X. Coinsurance		days () ()						
Y. TOTAL DEDUCTIONS								
29. I certify that the required physician's certification and recertifications are on file.								
Signature of provider representative				Date forwarded		35. Approved by		
						Date approved		

20. Statement covers period	
FROM	THRU
21. Date guarantee of payment began	22. Date UR notice received
23. Date active care ended	24. Date benefits exhausted
25. Patient status	
A. Date discharged	B. Date of death
C. <input type="checkbox"/> Still patient	
26. Lifetime reserve days used	27. Leave days
28. Covered days	
30. Remarks: PIP per diem amount \$	
31. Reimbursement amount \$	
FOR INTERMEDIARY USE	
32. Verified non-covered stays	33. Non-pmt. code
From	Thru
34. Days used	

402. INPATIENT HOSPITAL AND EXTENDED CARE ADMISSION AND BILLING (FORM SSA-1453)

This form serves two purposes. It is used to report the admission of a patient who is eligible for hospital insurance so that the Social Security Administration and the hospital's intermediary can determine how many benefit days are available. It is also used to bill the intermediary for the payment due the hospital for the services rendered.

The bottom two copies of the form can be used to report the admission. (The procedures for reporting admissions are described in the Admission Procedures Chapter.) The hospital fills out items 1 through 16 of all copies of the form, **detaches the bottom two copies**, and notifies the intermediary in accordance with its usual procedures. (If the two copies allotted for admission notification are not used for this purpose, they may be destroyed.)

The instructions for using the intermediary's Report of Eligibility to determine the number of days for which payment can be made and any deductibles for which the patient is responsible are contained in § 315.

Items 17 through 30 of the billing form should be completed at the time the bill is rendered. The bill may be rendered at the time the patient is discharged or after his benefits are exhausted. It also may be submitted on an interim basis.

A billing form should also be submitted even though no program payment can be made--

- a. for periods after benefits are exhausted. This means that lifetime reserve days were exhausted or the patient elected not to use them;
- b. when services are not covered;
- c. for the period after a utilization review finding that services are not medically necessary;
- d. when services are paid for, or can be expected to be paid for, by workmen's compensation;
- e. when services are paid for, or will be paid for by a National Institutes of Health grant;
- f. when the patient or his representative refuses to request that payment be made on his behalf;

g. when the physician refuses to certify for a reason other than lack of medical necessity.

Such bills enable the Social Security Administration and the intermediary to maintain correct current records of deductibles and days available. It is not necessary to complete all the items on a form when there are no covered days.

See § 450 for the procedures for completing and submitting this kind of bill.

A hospital bill is also required when the deductible covers the entire amount of the hospital charges. A full bill is completed in these cases.

402.1 Completion of Billing Items on the Form SSA-1453.--

Item 17. Discharge or Current Diagnoses. Enter here all of the diagnoses shown on the face sheet or discharge sheet of the patient's hospital record which relate to the condition requiring the current hospitalization. The primary diagnosis, shown in (a), is the diagnosis of the illness or condition which was the primary reason for the patient's hospitalization. Other diagnoses should be shown in (b). The diagnoses should be shown in accordance with recognized nomenclature, e.g., "International Classification of Diseases Adapted," "Current Medical Terminology," or "Standard Nomenclature of Diseases and Operations."

Item 18. Surgical Procedures. Surgical procedures should be specified in detail using recognized nomenclature such as that used in "Current Medical Terminology," ^{Current Procedural Terminology} "Standard Nomenclature of Diseases and Operations," etc. For the purpose of this form, surgery includes incision, excision, amputation, introduction, endoscopy, repair, destruction, suture, and manipulations.

Enter the name of the procedures, if any, shown on the face sheet or discharge sheet of the patient's hospital record which were performed during the period covered by the bill. Show the dates of each operation or endoscopic procedure listed. List first those procedures related to the primary diagnosis. List all other operation and endoscopic procedures in the same order as is shown on the face sheet or discharge sheet.

Item 19. Statement of Services Rendered. Show all charges for the period covered by the current billing for each of the departments. Where your hospital has more departments than shown on the form,

combine the charges, where appropriate, for the purpose of completing the form. Where charges for a department not listed on the form are applied to one of the departments listed, all bills submitted should apply the same charges consistently to the same departments.

For instance, if Recovery Room is applied to line H--Operating Room, this should be done on a consistent basis, and should not be listed on line T--Other--on any bills submitted. Where there is insufficient space to describe all the services performed in T, Other, it is permissible to combine all other charges. Continuation sheet attachments for charges are not to be used. However, if it is necessary to explain a particular item, this may be done on an attachment.

Machine-Produced Ledger Sheets. Where the hospital wishes to submit machine-produced ledger sheets in lieu of the detailed completion of the Statement of Services item, it may do so if it has been following this practice for other insurance plans. The bill submitted by the hospital should contain departmental totals or sub-totals. Hotel-type billings which summarize by day but not by department are not acceptable. Where the days, rate, and type of accommodation are not clear from the machine bill attachment, the hospital will make the accommodation entries. Also, unless blood furnished, not replaced, and charge per pint are shown on the attachment, the hospital should enter the blood information on line A.

Charges for services which are not covered should be fully identified either on the ledger sheet attached or in the "Noncovered Charges" column, unless such charges are routinely billed to all patients per discussion in Total and Noncovered Charges, below.

Any attachments, whether a machine bill or an explanation, should show the patient's name and health insurance claim number and the hospital's name and address.

Showing Discounted Charges. Credit or minus entries should not be shown on the billing form.

Where the hospital gives a discount to some patients, it can show charges in one of two ways. The charges can be shown as the full, undiscounted charge if full undiscounted charge data is accumulated for all patients for the purposes of the final cost reimbursement. The charges for the individual departments on the billing form should be shown as the discounted charges if the hospital, for the purposes of the final cost reimbursement, accumulates charges for all patients at the discounted rate.

Total and Noncovered Charges. In the Total Charges column the total charge for all services, covered and noncovered, will generally be shown. See item 19B for the entries to be made when a patient is furnished private accommodations neither for medical reasons nor at his request, and the excess over semiprivate accommodations will not be charged to him; and see item 19H-T for the rules for entries when items or services are furnished which are more expensive or in excess of those covered by the program.

In the Noncovered Charges column, enter the amount of any noncovered charge except where the noncovered charge is routinely billed to medicare and nonmedicare patients alike. For instance, if it is the hospital's practice to bill nonmedicare patients for anesthetic services which include the anesthesiologist's services as an integral part of the anesthetic charge, the hospital should show the total anesthetic charge, including the anesthesiologist's component in the Total Charges column without breaking down the physician's component in the Noncovered Charges column.

Where the SSA-1453 is used to bill for the Part B inpatient hospital services of pathologists or radiologists effective April 1, 1968, no separate billing is required. The combined billing method may be used for pathologists' and radiologists' services where it is consistent with the hospital's usual charging practice and the billing form includes professional component charges. For physicians' services of other than pathology and radiology there should be a separate Part B billing by the hospital on behalf of the physician or by the physician on his own behalf for services to the patient. For all pathologists and/or radiologists furnishing inpatient services in the hospital who do not bill patients directly, the hospital must either use the combined billing method or the SSA-1554 billing method.

Of course, if the hospital bills patients for services which do not include the physician's component, the physician's component would not be shown in Total Charges. The purpose of this method of reporting is to maintain the integrity of the ratio of costs to charges for the final cost reimbursement settlement, which requires a uniform accounting report for medicare and nonmedicare patients.

Physicians' services and any other services not covered under Part A cannot be applied to the deductible. See the explanation for line V, Inpatient Deductible.

Where a bill is submitted for a period including both covered and noncovered days (e.g., benefits exhausted during billing period),

the charges for noncovered days are listed under noncovered charges. Where a billing form covers only noncovered days, only line U, Totals, need be completed. See § 450 on submitting bill for noncovered days.

Item 19. Statement of Services Rendered.

A. **Blood.**--(See §§ 222 and H222 for an explanation of the deductible.)

Pints Furnished.--Enter the total number of pints of whole blood or packed cells furnished, whether or not replaced. This entry serves as a basis for counting pints toward the blood deductible and must therefore include both replaced and unreplaced blood.

Pints Replaced.--Enter the total number of pints which were donated on the patient's behalf. Where 1 pint is donated, 1 pint will be considered replaced. Any blood which is furnished by a blood bank on behalf of the patient at no charge to the hospital is considered as replaced blood. If arrangements have been made for replacement, although the blood may not be replaced at the time of billing, the pints will be shown as replaced.

Not Replaced.--Enter the difference between the pints furnished and the pints replaced.

Charge Per Pint.--Where the patient does not replace all of the blood furnished pint-for-pint, the hospital will show its usual charge per pint for unreplaced blood in the charge item. If more than one pint is furnished and the charge per pint is not the same for each pint, the highest charge will be entered with an asterisk above the entry. In this case, the hospital should enter the specific rates in remarks.

Where a blood bank makes a "service" charge, and this charge applies equally to replaced and unreplaced blood, this charge will be considered a processing cost and will be charged to the program (on line K) and not to the patient.

Example 1: The patient is furnished four pints of blood by a blood bank which donates the blood and makes a service charge of \$3 for each pint of blood whether replaced or not. This \$3 charge per pint is a processing cost and no charge may be made to the patient. The entries for this situation would be as follows: Blood Pints Furnished--4; Pints Replaced--4; Not Replaced--0. No entry is made in the Charge-Per-Pint Block or the Total Charges column of line A. On line K \$12 (\$3 x 4 pints) is shown in the Total Charges column.

Where a blood bank makes a "service" charge for only unreplaced blood, this charge will not be considered a processing charge. but a charge for whole blood. Therefore, the service charge for any of the first three pints of unreplaced blood subject to the blood deductible may be charged to the patient.

Example 2: The patient, who had 2 pints of the deductible remaining at the time of the present hospitalization, is furnished 4 pints of blood by a blood bank which donates the blood and makes only a service charge of \$3 per pint for blood which is not replaced. This \$3 a pint charge for unreplaced blood is not a processing cost but is considered the cost of the blood to the hospital. If the patient replaced only 1 pint of blood, the entries would be as follows: Blood Pints Furnished--4; Pints Replaced--1; Not Replaced--3; Charge Per Pint--\$3; Total Charges--\$9. Unless the hospital charges its own administrative or processing charges, no entry would be made on line K. In line W, one pint at \$3 a pint will be shown as the patient's deductible liability.

Total Charge.--This should reflect the charge for unreplaced blood plus any additional charge which the hospital paid to an outside blood bank for blood that was not fully replaced under the blood bank's replacement requirement.

A hospital which operates its own blood bank may not enter extra charges where it usually requires more than 1 pint of blood in replacement for each pint furnished.

Example 1: A hospital operates its own blood bank. It furnishes 3 pints of blood and the patient replaces 3. The hospital may not charge the patient for any of the 3 pints furnished and it shows no charge in "Total Charges" for any replaced blood.

Where the hospital obtains blood from a blood bank, charges for blood furnished by the hospital to the program and to the patient for the blood deductible depend on the blood bank's bill to the hospital.

Where all the blood has been replaced according to the blood bank's replacement requirements, no charge is made to either the program or patient for blood. Any service charge should be shown on line K as a blood administration charge.

Where not all of the blood has been replaced according to the blood bank's replacement requirements, no charge is made to the patient if he replaces enough pints on a pint-for-pint basis to meet the blood deductible. If this requirement is not met, he may be charged for pints which are not replaced at the same charge per pint to the hospital as the pints furnished to him.

The amount to be entered in Total Charges on line A is usually the total charge made by the blood bank after the patient's

replacement has been taken into account. However, this amount is subject to a maximum, which is determined as follows:

(1) Multiply the charge per pint by the number of pints furnished but not replaced.

(2) Multiply the charge per pint by the number of pints furnished but replaced. Take two-thirds of this figure and add it to the amount in (1).

Example 2: The patient is furnished 9 pints and replaces 2. The charge per pint furnished was \$30. The blood bank credits the hospital with \$30 for the 2 pints which were replaced. The blood bank bills the hospital \$240 for blood.

The hospital computes the maximum total charges for blood to be entered on line A ($7 \times \$30$ plus $2 \times \$30 \times 2/3$). The maximum is \$250; therefore, \$240 is less than the maximum and is entered on line A. The hospital charges the patient for 1 pint at \$30 and this amount is entered on line W.

Example 3: The patient is furnished 6 pints and replaces 3. The charge per pint furnished is \$20. The blood bank credits the hospital with \$15 for the 3 pints which were replaced. The blood bank bills the hospital for \$105.

The hospital computes the maximum total charges for blood to be entered on line A ($3 \times \$20$ plus $3 \times \$20 \times 2/3$). The maximum is \$100. The charge by the blood bank exceeds the maximum and \$100 is entered on line A. No entry is made on line W since the patient has met the blood deductible by replacement.

In completing line A, the Noncovered Charges column is used only where some blood charges are not covered or cannot be applied toward the deductible because, for example, they were incurred after exhaustion of Part A benefits.

No charge may be made to the patient for any costs of processing, administration, or packaging. Blood processing, administration, and packaging charges should be shown on line 19K.

Items B-F. Accommodation. See § 210.1 for an explanation of the rules governing when other than semiprivate accommodations are furnished.

The accommodation days should not include the day of discharge, even where the discharge was late.

However, where the hospital normally makes an extra charge for a late discharge, it should enter the extra charge in Total Charges. Where this charge was made because the patient remained in the hospital after checkout time for his own convenience, the charge may be made to the patient and should be entered in the Noncovered column as a noncovered charge. However, where a patient's stay beyond the checkout hour is occasioned by his medical condition, e.g., a bedridden patient awaiting transfer to his home or to an extended care facility, the services furnished by the hospital are covered charges.

Ancillary charges for day of discharge, death, or the day on which a leave of absence begins, should be shown in the proper department.

Where the patient is discharged on his first day of entitlement, it is permissible to submit a billing form with no accommodation charge, but with ancillary charges shown on lines A and H through T.

Where some of the days cannot be paid for under Part A because benefits were exhausted before discharge or death, show the charges for days after benefits were exhausted under noncovered charges.

Where more than one rate has been used for a given type of accommodation, one of the unused accommodation lines may be relettered and used to show the entry.

Example: Patient spends 10 days in a two-bed room at \$25 per day and is then moved to a four-bed room at \$22 per day. Line D, which was not used, may be relettered C and used to show the second accommodation.

B. One Bed.--Where a patient needed a private room for medical reasons, complete and attach one copy of form SSA-1484 to explain the medical necessity.

Enter the customary charge for a one-bed room accommodation in the "Rate" column and complete the "Total Charges" column.

If the patient was in a one-bed accommodation for other than medical reasons, payment cannot be made for more than the cost of semiprivate accommodations. (The completion of Form SSA-1484, Explanation of Accommodation Furnished, is not necessary in this case.)

1. If the patient requested a private room, the patient may be charged the difference between the private room charges and the

most prevalent semiprivate room charges at the time of admission. If the hospital will charge him the difference, complete item 19B showing the days, rate, and total charges for the private room accommodations.

In the Noncovered Charges column, show the difference between the private room charges and the most prevalent semiprivate room charges at the time of admission. (If the hospital does not charge the patient, complete item 19C as in 2 below.)

2. If the patient did not request a private room, no charge may be made to him. In such a case, enter the most prevalent semiprivate rate, and the charges in the Total Charges column of item 19C. No entry should be made in the Noncovered Charges Column.

(See § 412.2, item 6, for the method of figuring the most prevalent semiprivate rate. When the hospital is one which has only private accommodations, the most prevalent semiprivate accommodation rate is not applicable. In such a case, the hospital will use the equivalent semiprivate rate established by the intermediary in place of the most prevalent semiprivate rate (see § 210.1B).)

C. 2-3-4-Bed.--If the patient occupies semiprivate accommodations (2, 3, or 4-bed room) show the number of days and the actual daily rate for the accommodations.

D. 5 or More Beds.--Under the hospital insurance program, payment is ordinarily made for semiprivate accommodations (2, 3, 4-bed room). If the patient is assigned to a room with 5 or more beds, the hospital should complete Form SSA-1484, Explanation of Accommodation Furnished, explaining the reasons for this accommodation. Two copies of the form should be prepared and attached to the billing form, where the patient did not request the accommodation. Where the patient requested the accommodation, only one copy of the SSA-1484 is required for attachment to the billing form. (See § 412 for instructions on use of Form SSA-1484 and completion of items.)

Where the patient requested a five or more bed assignment, or the reason for assignment is one that the intermediary can approve, the reimbursement will be made for the reasonable cost of the actual accommodation furnished. However, where the ward accommodation was provided not at the patient's request, nor for a reason which the intermediary can approve, payment will be made, at the end of the year settlement, on the basis of the reasonable cost of semi-private accommodations minus the difference between the hospital's

customary charges for semiprivate accommodations and its customary charge for ward accommodations. In either case, the customary ward charge should be shown in the "Rate" column on the billing form.

E and F. Intensive Care and Self-Care.---Show the number of days the patient was in an intensive and/or self-care unit, applicable rate, and total charges.

Sometimes the patient will only be present in the intensive care unit for a few hours. In this case, the additional charges, without accommodations days, may be shown on line E, and the usual accommodation days shown on line B, C, or D. This is an acceptable method provided the intensive care charge excludes any charge for accommodation, and no days are shown in the intensive care days column.

G. PIP Total.---For hospitals using the periodic interim payment (PIP) method of reimbursement, the total accommodation charges and total noncovered accommodations should be entered here.

H-T. General.---Item H includes recovery room and item L includes intravenous solution. Item J represents routine charges originating in the outpatient department which are furnished to an inpatient; although these services may originate in the outpatient department, they are inpatient costs for the purposes of the medicare cost settlement.

Where items and services are furnished which are more expensive or in excess of the services covered by the program, the entire to be made in the Total Charges and Noncovered Charges column will be as follows:

1. If the patient did not request such excess or more expensive services, the patient may not be charged for the excess services, and only the services covered by the program should be shown in the Total Charges column. No entry is made in the Noncovered Charges column in this situation. (However, where all patients are routinely billed for such excess or more expensive items the Total Charges column may reflect the excess items or services as discussed in Total and Noncovered Charges, above.)

2. If the patient did request such excess or more expensive services, the patient may be charged for the excess services by the hospital. In this case, show the total charges (any customary charges covered by the program plus the excess charges) in the Total Charges column. In the Noncovered Charges column, show the excess charges which will be billed by the hospital to the patient.

3. In the same situation as cited in 2 above, except that the hospital will not bill the patient for the excess services, show only the customary charges for covered services in the Total Charges column and make no entry in the Noncovered Charges column.

U. Totals.--The sum of all total charges and noncovered charges should be shown in this item.

V. Inpatient Deductible. The completion of this item depends on the remaining deductible that is shown on the report of eligibility received in reply to the Notice of Admission.

a. Report of Eligibility Shows Remaining Inpatient Deductible as "None."--No entry should be made on line V in this situation.

b. Report of Eligibility Shows \$40 as the Remaining Inpatient Deductible.--

(1) If line U, Total Charges, shows an amount equal to or greater than \$40, show \$40 as the inpatient deductible amount on line V.

However, if the charge for physicians' services (including radiologist's and pathologist's services) has been included in Total Charges (see discussion of the Total and Noncovered Charges columns, above), the physicians' services charge should be subtracted from Total Charges. If this results in covered charges of less than \$40, show the amount of the covered charges. Noncovered charges do not count toward the inpatient deductible.

Example: The report of eligibility shows the remaining inpatient deductible as \$40. The Total Charges column on line U is \$42 and the charge for pathologists' services included in the \$42 is \$5. Therefore, the covered charges for deductible purposes would be \$37. Show this amount on line V.

(2) If line U, Total Charges, shows an amount less than \$40, enter the amount shown on line U as the inpatient deductible amount. If, as in (1) above, the Total Charges column includes charges for physicians' services, the difference between Total Charges and the physicians' services charges is the amount to be entered on line V.

Where the Total Charges on line U (or the difference between line U and physicians' services charges) are actual charges which are less than customary charges, the proper entry on line V would be the customary charges. (See § 220.)

c. Report of Eligibility Shows Part of the Inpatient Deductible Remaining to be Met.--Follow the rules in b, above, but use the amount of the remaining deductible as shown on the report of eligibility rather than \$40.

W. Blood Deductible.--The dollar value of the whole blood or packed cells for which the patient is responsible for paying is shown on line W. The patient is responsible for paying for whatever is not replaced in the first 3 pints furnished during a spell of illness. If the blood replaced equals the blood deductible shown on the intermediary's reply to the Notice of Admission, no entry is made on line W. However, if less blood is replaced than the remaining pints shown on the reply, the charge for unreplaced blood which went toward the deductible must be shown so that the appropriate deduction can be made in the reimbursement to the hospital. When the provider discounts the customary charges for unreplaced blood to which the deductible applies (see item A), show charges after discount in this item.

X. Coinsurance.--The coinsurance days are the 61st through the 90th day of the spell of illness, plus the lifetime reserve days used.

The rate for the spell of illness coinsurance days is \$10 or the daily charge, whichever is less.

The rate for lifetime reserve days is \$20. If the average daily charge for the lifetime reserve day period is \$20 or less, no entry should be made and lifetime reserve days should not be charged. (See item 26.)

Enter the total number of \$10 and \$20 coinsurance days before the "days" item.

If only one type of coinsurance is involved, enter the rate between the first parentheses.

If both types of coinsurance are involved, enter the days and the rate for the spell of illness coinsurance between the first parentheses and the days and rate for the lifetime reserve coinsurance between the second parentheses.

Y. Total Deductions.--This is the total of lines V, W, and X. It does not include any noncovered charges shown on line U.

Item 20. Statement Covers Period. The inclusive days being reported on the bill whether or not these days are covered will be entered. Days before the patient's entitlement to hospital insurance will not be included.

On interim bills the "Thru" entry will be the last day billed. On the last bill submitted, the "Thru" entry will show the date of discharge or death.

Example: A hospital follows the practice of billing the intermediary on the 15th and last day of each month. The patient is admitted on February 5, 1968, and discharged March 14, 1968. Assuming that all days are covered, "Statement Covers Period" and "Covered Days" would be completed as follows:

	<u>FROM</u>	<u>THRU</u>	<u>TOTAL DAYS</u>
First Bill	02/05/68	02/15/68	11
Second Bill	02/16/68	02/29/68	14
Third Bill	03/01/68	03/14/68	13

Item 21. Date Guarantee of Payment Began. Enter here the first day for which payment is being claimed under the guarantee of payment provision. Any payment made under this provision is at the full scale and not subject to coinsurance. Do not use this block for any other purpose.

The guarantee of payment provision will not apply if the patient has remaining available days in the spell of illness equal to or greater than the number of days included in the period of 6 workdays after the date of admission. Remaining available days **include** lifetime reserve days. Payment cannot be made under this provision for any day after the day the hospital receives the reply to the notice of admission.

Example 1: The patient is admitted to the hospital on Tuesday, March 5, 1968, and the requirements for payment under the guarantee provision in § 286.1 A, B, and C are met. The patient is still hospitalized on 3/15/68 when the reply to the notice of admission is received by the hospital showing 9 lifetime reserve days available for the spell of illness. Six workdays after the day of admission of 3/5/68 is 3/13/68, a total of 9 calendar days. Therefore, the maximum payment under the guarantee provision for this stay could only be for 9 days. Since the patient has 9 days remaining eligibility, the guarantee **does not** apply and no entry should be made in item 21.

Example 2: The circumstances are the same as Example 1, except that the reply shows only 3 lifetime reserve days available. The guarantee **does** apply and if the hospital wishes to claim payment under this provision, the entry in item 21 should be 03/08/68, the first day

for which payment is claimed under the guarantee. Payment under the guarantee can be made for a total of 6 days for this stay, from 3/8/68 through 3/13/68, the sixth workday after admission.

Example 3: The circumstances are the same as Example 1, except that the reply shows no days available. The guarantee **does** apply and if the hospital wishes to claim payment under this provision, the entry in item 21 should be 03/05/68, the first day for which payment is claimed under the guarantee. For this stay, payment can be made under the guarantee for a total of 9 days, from 3/5/68 through 3/13/68, the sixth workday after admission.

The guarantee of payment provision does not apply unless the hospital establishes that it acted in good faith assuming the individual was entitled to have payment made for hospital services, and acted reasonably in assuming that the patient's inpatient days had not been or were not about to be exhausted. (See § 286.) Where the guarantee of payment applies, the hospital should attach a statement explaining the circumstances and itemize any payment received, or refunds made toward the bill.

Item 22. Date UR Notice Received. Enter the date of receipt by the hospital of the finding by the physician members of the utilization review committee (or the group responsible for review of utilization) that a further hospital stay was not medically necessary. Do not use this block for any other purpose.

Item 23. Date Active Care Ended. Psychiatric and tuberculosis hospitals will indicate the date, if any, on which active treatment ended. If this is an interim billing and the patient is still receiving active treatment, make no entry here. General hospitals will not use this space.

Item 24. Date Benefits Exhausted. Enter the last day for which benefits are being claimed. An entry should be made in only two situations:

1. The regular 90 spell of illness days have been exhausted and the patient elects not to use lifetime reserve days, or

2. All spell of illness days and lifetime reserve days have been exhausted.

No entry should be made when the reply to the notice of admission showed that no days (including lifetime reserve days) are available. This item should be completed only where benefits are exhausted

before the date of discharge or death, and during the period described in item 20. A projected date should not be used.

Item 25. Patient Status. If the patient was discharged, enter the date of discharge in A. If the patient is deceased, enter the date of death in B. If the patient is still hospitalized when the billing is submitted, check C, Still Patient.

Item 26. Lifetime Reserve Days Used. Enter the number of lifetime reserve days used during the billing period. This should equal the number of lifetime reserve coinsurance days shown on line 19X. No days should be shown where the hospital's charges are \$20 or less per day. To determine whether charges are less than \$20 a day for a lifetime reserve day period, the hospital should average the total covered charges over the reserve day period. A hospital whose daily accommodation charge is less than \$20 must prepare a separate billing for the lifetime reserve day period when they are billing for payment for lifetime reserve days.

Hospitals are required to notify the patient of his right to elect not to use lifetime reserve days before billing the program for in-patient hospital services furnished after the 90th day in the spell of illness. Hospitals should appropriately annotate their records at the time they inform the patient of his option.

The hospital need not obtain the patient's election to use lifetime reserve days, if at the time of admission the patient had fewer regular days available in the spell of illness than were necessary to cover the period of 6 workdays after the date of admission. In this situation, the hospital may bill for the number of lifetime reserve days needed to cover the period if they wish to do so, without the patient's election.

Item 27. Leave Days. Enter the number of days on which the patient was not present in the hospital and for which the hospital is not being reimbursed. Attach a brief explanation to the billing form or in item 30.

Where a patient on leave of absence who was shown as "Still Patient" has not returned within 60 days, including the day the leave began, a corrected bill should be submitted per § 450 showing the day the patient left the hospital as the day of discharge. This will close the "open item" on the patient's utilization record. A notice of admission will be necessary if the patient returns after a 60-day absence.

Item 28. Covered Days. Enter the total covered days, including lifetime reserve days used. Covered days should not include:

- a. days for which no payment can be made because benefits are exhausted, unless the guarantee of payment applies;

b. days for which no payment can be made because a workmen's compensation payment is being made or can be expected to be made;

c. days for which no payment can be made because payment will be made under a National Institutes of Health grant;

d. days for which services are not covered. This includes, for example:

1. emergency services after the emergency has ended;

2. days for which inpatient care was not medically necessary (e.g., custodial care case);

e. days for which no payment can be made because the patient was on a leave of absence or was away from the hospital because of repeated admissions and discharges;

f. day of discharge or death.

Except for a. and f., the hospital should include a brief explanation of the reason why days are excluded in the Remarks block (item 30), e.g., "Workmen's Compensation," "Noncovered Services," etc., and should give the precise dates for which no payment is being claimed. (See § 450 for procedure for submitting billing in no-payment situations.)

Where a patient is admitted as an inpatient with the expectation that he will stay overnight but he is discharged before midnight, "1" will be entered in Total Days. Where a patient is transferred to another hospital before midnight (after admission with the expectation that he would remain overnight), "0" will be entered in this item. An accommodation charge may be made in this case even though Total Days will be entered as "0."

Where a patient is discharged on the first day of his entitlement, "0" will be shown in this item and no accommodation charge may be made.

Item 29. Hospital Certification and Signature Line. When a certification or recertification is required, a hospital representative should make sure that the physician's certification and recertifications are in the hospital records. No signature is required for a general hospital stay unless a certification is required, i.e., a stay of 14 or more days. In all cases, the form should be dated before it is submitted to the intermediary. A stamped signature is

acceptable. The date forwarded should be the date the bill is actually forwarded to the intermediary. The date used should not be before the "Thru" date in the "Statement Covers Period" item.

Item 30. Remarks. This block will be used by the hospital and/or intermediary. The intermediary may show the computation of interim cost reimbursement here.

If the hospital is being reimbursed under the PIP method, the intermediary will enter the estimated daily cost next to the "PIP per diem amount" item.

Item 31. Reimbursement Amount. The intermediary will enter the interim reimbursement amount here. This is the estimated costs of covered services less the total deductions.

For Intermediary Use

Item 32. Verified Noncovered Stays. The intermediary will enter here the dates of any noncovered stays which affect the spell of illness. Stays will be shown here only if they extend a spell of illness. If more than one stay is involved, the admission date of the first stay and discharge date of the last stay will be shown.

Item 33. Nonpayment Code. Whenever payment is not being made to the hospital for the entire billing period for any reason, the intermediary will indicate one of the following codes:

- W - Workmen's Compensation
- C - Custodial Care
- B - Benefits Exhausted
- R - Spell of Illness Benefits Refused or Certification Refused
- N - All other reasons for nonpayment (e.g., entire bill is for noncovered services, emergency denied, National Institutes of Health grant, VA preclusion, etc.)

Where code R has been previously reported but a corrected billing reflects that the patient has now requested payment or the physician has agreed to make a certification, code P will be shown in this item.

If a stay begins as noncovered and later becomes covered, split bills are required. (See § 450.)

Item 34. Days Used. An entry will be made here for all bills from a psychiatric hospital for the first spell of illness where a reduction

is applied to days available because the beneficiary was an inpatient of a psychiatric hospital on his first day of entitlement to hospital insurance. The entry will be the number of days, not necessarily consecutive, in which he was confined to a psychiatric hospital in the 150-day period immediately preceding entitlement.

Item 35. Approved By and Date Approved. The identification of the intermediary official approving the bill and the date approved will be entered in the appropriate items.

402.2 All-Inclusive Rate Hospitals.--For hospitals using all-inclusive rates, the line for the accommodation actually furnished is to be completed. The number of days, all-inclusive rate, total charges, and noncovered charges must be entered on the bill.

If the patient was furnished more than one type of accommodation, the lines for each type of accommodation are to be completed. This is necessary whether or not the hospital charges an all-inclusive rate according to accommodations.

In hospitals where the all-inclusive rate varies with the type of accommodation, an SSA-1484, Explanation of Accommodation Furnished, should be completed for a medically necessary private accommodation or for five or more bed accommodation. The semiprivate all-inclusive rate should be shown on the SSA-1484.

Item A. Blood. Whenever whole blood or packed cells is furnished in hospitals using all-inclusive rates, line A must be completed. If the all-inclusive rate does not include the charge for blood, line A should be completed in the same way a hospital not using all-inclusive rates would complete this item. Pints furnished, pints replaced, pints not replaced, and charge per pint for the blood itself should be shown.

If the all-inclusive rate covers the cost of providing blood whenever a patient needs it, the number of pints furnished, replaced, not replaced, and the estimated cost per pint should be entered on line A. It is not necessary to show any amount in the Total Charges column. The cost of any of the first 3 pints which are not replaced should be shown on line W. It is not necessary to show the cost for any replaced blood in item 19.

Item V. Inpatient Deductible. As with hospitals having a schedule of charges for individual services, the amount of any **physician's component** included in the all-inclusive charge should be considered where the exclusion of the physician component would bring the charges below the remaining deductible to be met.

All-Inclusive Charges According to Disease, Injury, or Type of Treatment.--Those hospitals that have a charge system based on the patient's illness or injury or type of treatment should also complete the line(s) for type of accommodation showing number of days, rate, and total charges. The accommodation totals and the total amount (line U) should be the same. Blood entries will be made in the manner indicated above.

402.3 Disposition of Copies of Completed Forms SSA-1453.--Retain the copy designated "Provider Copy" and submit the remaining copies to your intermediary (or SSA in direct dealing situations). The remaining copies to be submitted to the intermediary or SSA constitute the following:

- a. The original copy which is maintained in the intermediary's (or SSA's) files.
- b. One copy designated "Social Security Administration Copy."
- c. The copy designated "Informational Copy." The intermediary will send this copy to the carrier processing physicians' bills if the carrier requests it. Otherwise, it may be used for welfare and complementary coverage purposes.



EXPLANATION OF ACCOMMODATION FURNISHED

1. PATIENT'S LAST NAME	2. HEALTH INSURANCE CLAIM NUMBER
3. HOSPITAL OR EXTENDED CARE FACILITY NAME AND ADDRESS	4. PROVIDER NO.
	5. MEDICAL RECORD NO.

TYPE OF ACCOMMODATION FURNISHED

6A. MOST PREVALENT SEMI-PRIVATE RATE			\$		
B. 1-BED			C. 5-OR-MORE-BED		
FROM (Date)	TO (Date)	RATE	FROM (Date)	TO (Date)	RATE

REASON FOR ASSIGNMENT TO ACCOMMODATION MENTIONED

7A. PATIENT'S REQUEST - The 5-or-more-bed accommodation shown above was furnished because I requested it.

PATIENT'S SIGNATURE	DATE
---------------------	------

B. MEDICAL NECESSITY (Describe)

C. OTHER REASON (Specify)

D. SIGNATURE OF HOSPITAL REPRESENTATIVE	8. DATE
---	---------

FOR INTERMEDIARY USE

9. Where intermediary determines that assignment to 5-or-more-bed room was not at patient's request, or was not consistent with the purposes of the Act, give difference between total of charges for accommodation at the most prevalent 2-3-4 bed room rate and charges for a 5-or-more-bed room for all covered days included on bill for services attached.	\$
10. INTERMEDIARY APPROVAL	DATE

412. EXPLANATION OF ACCOMMODATION FURNISHED (FORM SSA-1484)

Form SSA-1484, Explanation of Accommodation Furnished, is used by the hospital to explain an accommodation other than a two-, three-, or four-bed room.

The cost of a one-bed accommodation is covered by hospital insurance if it is medically necessary. In this case, only one copy of the form is required. The medical necessity for a private accommodation should be described on the SSA-1484 from the physician's order and the reason as given by him in the hospital's medical record. It is not necessary to attach a special statement from the doctor for this purpose.

Where the patient was furnished a one-bed accommodation for reasons other than medical necessity, it is not necessary to complete a form SSA-1484.

Where the patient requested a five-bed accommodation, the hospital should complete a single copy of the SSA-1484 for attachment to the bill and have the patient sign the form in the Patient's Signature block under item 7A.

Where the patient was assigned a five-bed accommodation not at his request, the hospital should complete the SSA-1484 in duplicate for attachment to the bill showing the reason for such assignment. Where such an assignment is made not at the patient's request and not for a reason the intermediary approves, i.e., a reason not consistent with the purposes of the program, the hospital may be subject to a special deduction in its cost settlement described in § 210.1C.

A hospital need not complete this form on individual claims where the intermediary had given its general approval for the omission of the form. This would usually only be given by the intermediary where the hospital has only five or more bed accommodations.

412.1 Completing Items on the Form SSA-1484.

Item 1: Patient Identification.--This should be the same name shown on the inpatient billing form to which the SSA-1484 will be attached.

Item 2: Health Insurance Claim Number: This should be the same number shown on the billing form.

Item 3: Hospital or Extended Care Facility Name and Address.--The name and address of the hospital is shown here.

Item 4: Provider Number.--This is the hospital's assigned health insurance provider number.

Item 5: Medical Record Number.--This is the patient's medical record number, if one is assigned by the hospital.

Item 6: Type of Accommodation Furnished.--This section calls for the period for which the accommodation was furnished and the applicable daily rate for the accommodation furnished. Item A, the most prevalent semiprivate rate, should be completed in all cases. This is the semiprivate rate most frequently used in the hospital. (A hospital with private rooms only will use the equivalent semiprivate rate determined by the intermediary.)

To determine the most prevalent charge for semiprivate accommodations, consider the following features:

1. Type of Accommodation.
2. Total rooms of each type for each different room rate.
3. Total beds found in each type for each room rate.
4. Rate you charge daily for the type of room.

Your most prevalent charge for semiprivate accommodations is that single rate you charge for the largest entry appearing under your "Total Beds" column.

Example:

(1) Type of accommodation	(2) Total rooms of this type	(3) Total beds col. (1) × col. (2)	(4) Rate per day
2 beds.....	10	20	\$30
2 beds.....	8	16	35
3 beds.....	2	6	20
4 beds.....	1	4	15

Note: \$30 is the most prevalent semiprivate charge.

Item 7: Reason for Assignment to Accommodation Mentioned.--

A. Patient's Request.--Where a five or more bed accommodation was furnished at a patient's request, the patient should be requested to sign the SSA-1484 in this item. Enter the date of signing.

B. Medical Necessity.--Describe the reason for assignment to a one-bed room from the physician's order shown in the hospital's records.

C. Other Reasons.--Where the hospital believes that an assignment to a five or more bed accommodation is justifiable for some other reason, it should describe the reason in this block.

D. Signature of Hospital Representative.--The responsible hospital representative should sign and date the form in this item. A stamped signature is acceptable.

Item 8: Date.--Show the date the signature in 7D was affixed.

Items 9 and 10: DO NOT USE.

PROVIDER BILLING FOR MEDICAL AND OTHER HEALTH SERVICES
MEDICAL INSURANCE BENEFITS - SOCIAL SECURITY ACT

Form Approved
 Budget Bureau
 No. 72-R0738

1. Patient's last name		First name	MI	2. Health insurance claim number	
3. Patient's address (Street number, City, State, ZIP Code)				4. Date of birth	5. Sex <input type="checkbox"/> M <input type="checkbox"/> F
6. Provider name and address (City and State)		7. Provider number		9. Type of service A. <input type="checkbox"/> Inpatient C. <input type="checkbox"/> Other (Specify) B. <input type="checkbox"/> Outpatient	
		8. Medical record number			

If you have other health insurance or if your State Medical Assistance Agency will pay part of your medical expenses and you want information about this claim released to them upon their request complete items 10 and 11.

10. Insuring organization or State agency name and address		11. Policy or medical assistance number	
12. Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related medicare claim. I request that payment of authorized benefits be made on my behalf.			
<input type="checkbox"/> Contained in provider's record	Signature (Patient or authorized representative) (Signature by mark must be witnessed)		Date

13. Nature of illness or injury		<input type="checkbox"/> Check here if illness or injury was connected with employment	Do not use this space
14. Surgical procedures			

15. Statement of services	Covered Charges	16. Statement Covers Period	First service	Last service
A. Clinic visit ()				
B. Emergency room ()		17. Blood Information	A. Pints furnished	B. Pints replaced
C. Laboratory			C. Pints	D. Charge per pint
D. Radiology		18. Professional component (hospital inpatients)		19. Other professional component
E. Pharmacy		A. Pathology		
F. Blood		20. Date benefits exhausted or HH plan terminated		21. Patient paid (Excluding I/E)
G. Ambulance				
H. Physical therapy		22. I certify that the required physician's certification is on file.		23. Date forwarded
I. Other (Specify)				
FOR INTERMEDIARY USE ONLY				
24. Verified Patient Liability				
		A. Blood deductible	B. Cash deductible	C. Coinsurance
		25. Payment Distribution		26. Date approved
		Provider	Patient	
J. TOTAL				

Remarks:

420. PROVIDER BILLING FOR MEDICAL AND OTHER HEALTH SERVICES (FORM SSA-1483)

This form will be used by a hospital after March 31, 1968, to report outpatient services and inpatient services covered under Part B where no payment is possible under Part A. The 8/66 version of the SSA-1483 should be used for outpatient hospital services furnished before April 1, 1968.

Outpatient hospital diagnostic services are not covered under Part A as of April 1, 1968. All diagnostic study periods for purposes of the \$20 Part A deductible will end no later than March 31, 1968. Outpatient diagnostic services are covered only under Part B as of April 1, 1968. Outpatient therapeutic services, as well as physicians' services, remain covered under Part B. Where the hospital bill includes charges for physicians' services, and the physician has authorized the hospital to collect from medicare on his behalf, generally these charges need not be separately identified.

A. When to Submit This Form.--The hospital may submit this form on a daily or timely cyclical billing basis. An SSA-1483 should be submitted in all cases when covered services are rendered without regard to whether the deductible has or has not been satisfied. No billing form should be submitted if (1) the patient is not enrolled under Part B, (2) it is obvious that only noncovered services have been rendered, or (3) workmen's compensation will pay the bill.

B. Determining How Much to Charge Outpatient Before Billing is Submitted.--The patient should be asked if he has with him an Explanation of Benefits form. The hospital is required to take into account the patient's deductible status shown on the most recent Explanation of Benefits form (see § 304). The hospital may also take into account any other information on the patient's deductible status available to it.

1. Charges for Billing Period Exceed \$50--No Blood Charges Are Included.--Where the deductible is known to be met, collect 20 percent of the total covered charges. Where the deductible is known to be met in part, collect no more than the unmet deductible and 20 percent of the remaining charge. When the deductible is not met or its status is unknown, charge no more than \$50 and 20 percent of the balance. The hospital, after billing the intermediary; should not collect or accept any money from the patient until the intermediary has notified the hospital of amounts applied to the deductible. Otherwise, the hospital is likely to receive duplicate payments from the patient and the program.

2. Charges for Billing Period Exceed \$50 Including Charges for Unreplaced Blood.--Payments for blood which go to meet the blood deductible do not count toward the \$50 cash deductible. If blood is furnished as well as other items or services not affected by the blood deductible, the hospital may charge the remaining blood deductible plus the remaining cash deductible and coinsurance.

3. Charges for Billing Period Are \$50 or Less Whether or Not Charges for Blood Are Included.--If the hospital does not know whether the \$50 cash deductible is met, it may collect from the patient the entire amount of the bill and the payment will be made to the patient for 80 percent of the charges over the unmet deductible. The difference between 80 percent of charges and 80 percent of costs will be adjusted in the hospital's final cost settlement. Where the deductible status is known, collect no more than the unmet deductible and 20 percent of the remaining charge. Where the patient's deductible status is unknown, the hospital may prefer to wait to bill the patient or to collect only 20 percent of the charge until the intermediary has verified such status.

4. Billing Examples.--

Example 1: The hospital knows that the patient has met the Part B deductible. No blood is furnished. Part B charges are \$100. The hospital may charge the patient \$20 (20 percent of \$100).

Example 2: The hospital knows the patient has met all but \$20 of the Part B deductible and all but one pint of the blood deductible. Two pints of blood are furnished at \$15 per pint, which are not expected to be replaced. The other Part B charges are \$60. The hospital may charge the patient \$46 (\$15 for blood deductible, plus \$20 cash deductible, plus \$11 coinsurance). The coinsurance is determined as follows:

Total charges not subject to blood deductible	\$75
Remaining Part B deductible	20
	<hr/> \$55
Coinsurance--20 percent of remainder	20%
	<hr/> \$11

C. Use of SSA-1483 to Bill for Part B Services Furnished to Inpatients.--Where Part A benefits are not payable to a participating hospital on behalf of a Part B beneficiary, e.g., Part A benefits are exhausted, the hospital will use SSA-1483 to report the charges covered under Part B. Payment is made to the hospital at 80 percent

of cost less any remaining Part B deductible. The following services are covered if the hospital bills for them:

1. Laboratory and other diagnostic tests;
2. X-ray, radium, and radioactive isotope therapy including services of technicians;
3. Surgical dressings and splints, casts and other devices used for the reduction of fractures and dislocations;
4. Prosthetic devices (other than dental) which replace all or part of an internal body organ, including replacement of such devices;
5. Leg, arm, back and neck braces and artificial legs, arms, and eyes, including replacement as required because of a change in the patient's physical condition.

Part B coverage for services furnished by a participating hospital to its inpatients is limited to the above items and services; any other services (except for physicians' professional services) are not covered under Part B if the hospital bills for them. The professional component of inpatient radiology and pathology services rendered after March 31, 1968, is covered at 100 percent under Part B; therefore, the amount of the professional component must be separately identified where the hospital component is also paid under Part B. The fact that certain services not covered under Part A may be covered under Part B and billed on the SSA-1483 does not affect the SSA-1453 admission and billing procedures. For example, a no-payment SSA-1453 is necessary upon discharge to close an open item if benefits are exhausted before discharge. (See § 450.)

420.1 Completing Items on Form SSA-1483.--

Item 1: Patient Identification.--Enter the patient's last name, first name, and middle initial from his health insurance card or other notice.

Item 2: Health Insurance Claim Number.--Enter the patient's claim number as shown on his health insurance card, certificate of award, utilization notice, or as reported by the social security district office.

Item 3: Patient's Address.--Show the patient's mailing address from your records. Where the patient's authorized representative is

applying on behalf of the patient, show the authorized representative's name and address. If the patient is an inpatient of another institution, enter the name of that institution.

Items 4 and 5: Date of Birth and Sex.--Enter the patient's date of birth and sex. If the date of birth is unknown, the hospital should transmit the bill without the date of birth. While the date of birth is useful as identification and should be shown when available, a billing can be processed without it.

Items 6, 7, and 8: Hospital Identification.--Enter the name and address of the hospital and the hospital's assigned provider number. These items can be preprinted on all copies of the form, if desired. Enter the patient's medical record number only if one is assigned by the hospital for its own filing purposes.

Item 9: Type of Service.--Check whether the service is inpatient or outpatient. Do not use "Other". Do not check more than one block. Ambulance service furnished by a hospital is considered an outpatient service. The block checked will reflect the relationship between the billing provider and the patient. If a provider is billing for services furnished an individual who is an inpatient of another institution, the name and address of the institution where the beneficiary is an inpatient should be shown as the patient's address in item 3.

Items 10 and 11: Complementary Coverage Information.--If information about the claim is to be sent to a complementary insurer at the patient's request and the hospital does not object, the name and address of the organization or agency should be shown. The identifying number will be shown in item 11.

Item 12: Patient's Certification.--Have the patient or his authorized representative read the statement on the form or the statement in the hospital admission record if the hospital uses the alternate signature procedure (see §§ 270ff).

If the hospital obtains the signature on its own form, check the block marked "Contained in Provider's Record." If the signature is obtained on form SSA-1483, it is sufficient if it is legible on the original only. A signature is required with each billing. If the hospital obtains a signature on its own record, see § 270.2B for the effective period of the signature.

If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf, e.g.,

John J. Jones by Jack A. Smith. In certain situations, a hospital representative may sign on behalf of the patient. (See § 271 for who may file a payment request.)

Briefly explain why the patient did not sign the form himself and show the relationship of the signer to the patient. This explanation should be retained in the hospital's file if the signature is obtained on the hospital's own record. If the signature is on form SSA-1483, the explanation should accompany or be included on the billing form.

The statement should be read to the patient who signs by mark. A signature by mark should be witnessed by a person who knows the patient. Enter the name and address of any person witnessing a signature by mark.

If it is impractical to obtain the patient's signature because he does not himself appear for diagnostic tests (e.g., the physician sent a blood or urine sample to a laboratory of a participating hospital for analysis), the hospital need not obtain the patient's signature. A hospital representative should sign on behalf of the patient and write in this item "Patient not physically present for tests." (See § 271 for additional information.)

Item 13: Nature of Illness or Injury.--List here, from the patient's hospital record, the nature of the illness or injury for which services were given. Acceptable medical terminology should be used, such as International Classification of Diseases Adapted, Current Medical Terminology, etc. If the nature of the illness or injury is not known, enter "not known". An entry must be made only for bills where the patient's health insurance number ends in "0," "4," "5," or "8."

If the condition was employment related, show the name and address of the employer, if known. Where the hospital knows that a workmen's compensation claim has been made, it should insert or attach a statement identifying the carrier, if any, handling the workmen's compensation claim and give any available details about the claim. It is not necessary to submit an SSA-1483 if it is known that workmen's compensation will pay the bill.

Item 14: Surgical Procedures.--The name and date of any operation or endoscopic procedure performed during the billing period should be shown. Use acceptable terminology, such as that indicated by the "Current Medical Terminology," "Current Procedural Terminology," "Standard Nomenclature of Diseases and Operations," "The American

Psychiatric Association's Diagnostic and Statistical Manual," etc. An entry must be made only for bills where the patient's health insurance number ends in "0," "4," "5," or "8."

Item 15: Statement of Services.--Enter the covered medical plan charges during the billing period. If the service was furnished under arrangements with suppliers outside the hospital but is being billed by the hospital, enter "U.A." by the type of service furnished. Cross-refer this to the name and address of the supplier in Remarks. Show the number of outpatient clinic visits during the billing period in A and the number of emergency room visits in B. Where blood is furnished on an outpatient basis, enter the charges for unreplaced blood on Line F. Show the charges for blood administration on Line I.

Do not show any charges for pharmacy, blood or physical therapy where the beneficiary is an inpatient of the hospital and no Part A benefits are payable, since these services and supplies are not covered under Part B. (See § 420C for covered services.)

Describe any durable medical equipment furnished to an outpatient for use in his home and indicate on Line I whether it is rented or purchased. Show the full purchase price if the equipment is purchased.

Show the total covered charges on Line J.

Item 16: Statement Covers Period.--Enter the dates of the first and last service furnished during the billing period. The date of the first service will always be later than the date of the last service on any preceding bill from the same provider. Do not bill for an inclusive period spanning two calendar years since the cash and blood deductibles apply to the charges incurred in each year independently. If the hospital knows that the Part B cash deductible was previously met, it can bill for an inclusive period spanning September and October; otherwise, separate bills are required.

Item 17: Blood Information.--See the instructions for completing item 19A of the SSA-1453, § 402.1, for an explanation of how to report charges by a blood bank to the hospital. Blood is covered under Part B only when the hospital furnishes it to an outpatient.

A. Pints Furnished.--Enter the total number of pints of whole blood or packed cells furnished the outpatient whether or not replaced. This entry serves as a basis for counting pints toward the blood deductible and must, therefore, include both replaced and unreplaced blood.

B. Pints Replaced.--Enter the total number of pints donated on behalf of the outpatient. Where 1 pint is donated, 1 pint will be considered replaced. If arrangements have been made for replacement, although the blood may not be replaced at the time of billing, the pints will be shown as replaced.

Report Pints Not Replaced as follows:

C. Pints.--Enter the difference between pints furnished and pints replaced in the "Pints" block.

D. Charge Per Pint.--Where the outpatient does not replace all of the blood deductible pints furnished, pint-for-pint, the hospital will show its usual charge per pint for unreplaced blood in the "Charge per pint" item. Where the charge is the same, the charge per pint multiplied by the pints of unreplaced blood should equal the charges on Line 15F. If more than 1 pint is furnished and the charge per pint is not the same for each pint, the highest charge should be entered with an asterisk above the entry. In this case, the hospital should enter the specific rates in Remarks.

E. Patient Paid for Deductible.--Where the outpatient does not replace all blood and the hospital collects a charge for blood which it believes will be needed to satisfy the blood deductible, enter in this block the amount actually collected. The outpatient is responsible for paying for whatever is not replaced of the first 3 pints of blood covered under Part B during the calendar year.

Item 18: Inpatient Pathology and Radiology Professional Component.--

For Part B inpatient hospital services only, where the combined billing is used, the amount of any pathology professional component charges included in item 15C should be shown in A. By the same rule, radiology professional component charges in item 15D should be shown in B. In order to use the combined billing method, the hospital must be consistent in its charging practice between medicare and nonmedicare patients and the gross charges, including professional component, must be included on the SSA-1483. Where the pathologist or radiologist professional component charges are billed on SSA-1554, the professional component charges would appear in item 19 of the SSA-1483.

Item 19: Other Professional Component.--For outpatient services where charges reported in item 15 include physicians' services but a separate billing is prepared for such charges, enter the amount of the professional component. These charges must be excluded on the SSA-1483 in determining the deductible and coinsurance due from

a patient in order to avoid duplication when the bill for physicians' services is processed by the Part B carrier. Make no entry here where the combined billing method is used.

Where the outpatient treatment is for mental illness, the physicians' charges must be billed for separately and any professional component charges included in item 15 must be indicated in item 19. This is because of the special payment limitation applicable to physicians' services in the outpatient treatment of mental illness (§ 245).

For inpatient services where the charges include physicians' services which are being billed separately, enter the amount of the physicians' charges. The professional component of inpatient pathology and radiology should be reported in item 18 where the SSA-1483 is to be used as a billing for the professional component of radiology and pathology.

Item 20: Date Benefits Exhausted or Home Health Plan Terminated.---

For Part B inpatient services only, enter the date that Part A benefits were exhausted if the patient was in your hospital when this occurred. In addition, if Part A inpatient benefits are not payable to your hospital for any other reason (e.g., adverse utilization review finding), enter the date on which the event occurred. If benefits are exhausted before admission, enter the date of the admission or the date on which the guarantee of payment ended, whichever is applicable.

Item 21: Patient Paid.---Enter the amount, if any, paid by the patient, excluding any amount in item 17E. Do not include any amount paid for physicians' services which will be separately billed. Do not collect any charges for inpatient pathology or radiology professional component charges from the patient.

Item 22: Signature of Hospital Representative.---Before the billing is forwarded to the intermediary, a hospital representative should assure himself that a physician's certification as to medical necessity is on file if a certification is required. A stamped signature is acceptable.

A certification is necessary when Part B services, except for Part B hospital outpatient services, are furnished. A certification is necessary for Part B hospital outpatient services only for ambulance services, rental or purchase of equipment, and laboratory services furnished by a laboratory which is independent of and not controlled by the hospital. This item need not be completed when the billing is for outpatient services for which no certification is required.

Item 23: Date Forwarded.--Enter the date on which the form was forwarded to the intermediary.

The balance of the form is for the use of the intermediary in computing the payments to be made to the hospital and/or patient.

The following examples illustrate the completion of the SSA-1483:

EXAMPLE 1:

The hospital does not know the patient's blood or cash deductible status. They collect \$20 for the blood deductible and the full amount of the regular Part B charges. Since the patient's health insurance claim number ends in "3," items 13 and 14 do not have to be completed. The SSA-1483 would be completed as follows by the hospital:

PROVIDER BILLING FOR MEDICAL AND OTHER HEALTH SERVICES
MEDICAL INSURANCE BENEFITS - SOCIAL SECURITY ACT

Form Approved
 Budget Bureau
 No. 72-R0738

1. Patient's last name Public	First name John	MI Q.	2. Health insurance claim number 000-00-0003A
3. Patient's address (Street number, City, State, ZIP Code) 123 Calendar Street, Anywhere, Pennsylvania 19000			4. Date of birth 0 6 0 4 0 1
6. Provider name and address (City and State) Memorial Hospital Anywhere, Pennsylvania 19000			5. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F
7. Provider number 000000			9. Type of service A. <input type="checkbox"/> Inpatient C. <input type="checkbox"/> Other (Specify) B. <input checked="" type="checkbox"/> Outpatient
8. Medical record number			

If you have other health insurance or if your State Medical Assistance Agency will pay part of your medical expenses and you want information about this claim released to them upon their request complete items 10 and 11.

10. Insuring organization or State agency name and address	11. Policy or medical assistance number
--	---

12. Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related medicare claim. I request that payment of authorized benefits be made on my behalf.

<input checked="" type="checkbox"/> Contained in provider's record	Signature (Patient or authorized representative) (Signature by mark must be witnessed)	Date
--	--	------

13. Nature of illness or injury	<input type="checkbox"/> Check here if illness or injury was connected with employment	Do not use this space
---------------------------------	--	-----------------------

14. Surgical procedures	
-------------------------	--

15. Statement of services	Covered Charges	16. Statement Covers Period	First service	Last service
A. Clinic visit (2)	16 00		0 4 0 8 6 8	0 4 1 8 6 8
B. Emergency room (1)	10 00	17. Blood Information	A. Pints furnished 1	B. Pints replaced 0
C. Laboratory			C. Pints 1	Not Replaced D. Charge per pint 20.00
D. Radiology		18. Professional component (hospital inpatients) A. Pathology B. Radiology		E. Patient paid for deductible 20.00
E. Pharmacy		20. Date benefits exhausted or HH plan terminated		19. Other professional component
F. Blood	20 00			21. Patient paid (Excluding I/E) 26.00
G. Ambulance		22. I certify that the required physician's certification is on file.		23. Date forwarded 0 4 2 1 6 8
H. Physical therapy		FOR INTERMEDIARY USE ONLY		
I. Other (Specify)		24. Verified Patient Liability A. Blood deductible B. Cash deductible C. Coinsurance		
		25. Payment Distribution Provider Patient		26. Date approved
J. TOTAL	46 00			

Remarks:

EXAMPLE 2:

The patient received outpatient services totaling \$39 including a professional charge of \$5 which is being separately billed on an SSA-1554. The patient makes no payment since the services will be paid for by a welfare agency. The name and address of the State Medical Assistance Agency is shown in item 10 and the medical assistance number is shown in item 11 of the SSA-1483. The SSA-1483 should be completed as follows by the hospital:

PROVIDER BILLING FOR MEDICAL AND OTHER HEALTH SERVICES
MEDICAL INSURANCE BENEFITS - SOCIAL SECURITY ACT

Form Approved
 Budget Bureau
 No. 72-R0738

1. Patient's last name Public	First name Mary	MI B.	2. Health insurance claim number 000-00-0000B
3. Patient's address (Street number, City, State, ZIP Code) 432 Peach Drive, Mudville, Missouri 21111			4. Date of birth 0 3 3 1 0 2
6. Provider name and address (City and State) Mercy Hospital 1000 Apple Orchard Boulevard Mudville, Missouri 21111			5. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F
7. Provider number 999999		9. Type of service A. <input type="checkbox"/> Inpatient C. <input type="checkbox"/> Other (Specify) B. <input checked="" type="checkbox"/> Outpatient	
8. Medical record number			

If you have other health insurance or if your State Medical Assistance Agency will pay part of your medical expenses and you want information about this claim released to them upon their request complete items 10 and 11.

10. Insuring organization or State agency name and address State Department of Welfare, 200 Pear St., Mudville, Mo. 21111	11. Policy or medical assistance number P-42367
---	---

12. Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related medicare claim. I request that payment of authorized benefits be made on my behalf.

<input type="checkbox"/> Contained in provider's record	Signature (Patient or authorized representative) (Signature by mark must be witnessed) <i>Mary B Public</i>	Date 5/3/68
---	--	-----------------------

13. Nature of illness or injury Fracture of wrist	<input type="checkbox"/> Check here if illness or injury was connected with employment	Do not use this space
---	--	-----------------------

14. Surgical procedures Closed reduction of fracture of wrist (5/3/68)	
--	--

15. Statement of services	Covered Charges	16. Statement Covers Period	First service	Last service
A. Clinic visit (2)	14 00		0 5 0 3 6 8	0 5 1 7 6 8
B. Emergency room (1)	10 00	17. Blood Information	A. Pints furnished	B. Pints replaced
C. Laboratory			C. Pints	Not Replaced
D. Radiology	15 00	18. Professional component (hospital inpatients)	19. Other professional component	
E. Pharmacy		A. Pathology	B. Radiology	5.00
F. Blood		20. Date benefits exhausted or HH plan terminated	21. Patient paid (Excluding I/E)	
G. Ambulance			-0-	
H. Physical therapy		22. I certify that the required physician's certification is on file.	23. Date forwarded	
I. Other (Specify)			0 5 2 1 6 8	
FOR INTERMEDIARY USE ONLY				
		24. Verified Patient Liability		
		A. Blood deductible	B. Cash deductible	C. Coinsurance
		25. Payment Distribution	26. Date approved	
		Provider	Patient	
J. TOTAL	39 00			

Remarks:

EXAMPLE 3:

The hospital is billing for inpatient services of radiology and pathology. The hospital uses the combined method of billing (bills for both hospital and professional component charges on the same bill).

The hospital knows that the patient has met his Part B cash deductible and collects \$17 coinsurance from him. This amount is arrived at as follows:

$$\begin{array}{r} \$100 - \text{total charges in 15J} \\ \text{less } \underline{15} - 18 \text{ A \& B (reimbursable at 100 percent)} \\ \quad \underline{\$ 85} \\ \text{times } \underline{20\%} \\ \quad \underline{\underline{\$ 17}} \end{array}$$

The SSA-1483 is completed as follows:

PROVIDER BILLING FOR MEDICAL AND OTHER HEALTH SERVICES
MEDICAL INSURANCE BENEFITS - SOCIAL SECURITY ACT

Form Approved
 Budget Bureau
 No. 72-R0738

1. Patient's last name Smith	First name John	MI T.	2. Health insurance claim number 000-00-0008A
3. Patient's address (Street number, City, State, ZIP Code) 1234 Main Street, Anywhere, Pennsylvania 19000			4. Date of birth 0 6 0 5 0 2
6. Provider name and address (City and State) Memorial Hospital Anywhere, Pennsylvania 19000			5. Sex X M <input type="checkbox"/> F
7. Provider number 000000			9. Type of service A. <input checked="" type="checkbox"/> Inpatient C. <input type="checkbox"/> Other (Specify) B. <input type="checkbox"/> Outpatient
8. Medical record number S-532			

If you have other health insurance or if your State Medical Assistance Agency will pay part of your medical expenses and you want information about this claim released to them upon their request complete items 10 and 11.

10. Insuring organization or State agency name and address	11. Policy or medical assistance number
--	---

12. Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related medicare claim. I request that payment of authorized benefits be made on my behalf.

<input type="checkbox"/> Contained in provider's record <input checked="" type="checkbox"/> Signature (Patient or authorized representative) (Signature of mark must be witnessed)		Date 05/01/68
---	--	-------------------------

13. Nature of illness or injury Gastritis	Check here if illness or injury was connected with employment <input type="checkbox"/>	Do not use this space
---	---	-----------------------

14. Surgical procedures	
-------------------------	--

15. Statement of services	Covered Charges	16. Statement Covers Period	First service	Last service
A. Clinic visit ()			0 5 0 1 6 8	0 5 1 0 6 8
B. Emergency room ()		17. Blood Information	A. Pints furnished	B. Pints replaced
C. Laboratory	40 00			C. Pints
D. Radiology	60 00	18. Professional component (hospital inpatients)	Not Replaced	
E. Pharmacy		A. Pathology	D. Charge per pint	E. Patient paid for deductible
F. Blood		5.00	10.00	
G. Ambulance		19. Other professional component		
H. Physical therapy		20. Date benefits exhausted or HH plan terminated	21. Patient paid (Excluding I/E)	
I. Other (Specify)		0 4 3 0 6 8	17.00	
J. TOTAL	100 00	22. I certify that the required physician's certification is on file. 		
Remarks:		23. Date forwarded 0 5 1 1 6 8		
		FOR INTERMEDIARY USE ONLY		
		24. Verified Patient Liability		
		A. Blood deductible	B. Cash deductible	C. Coinsurance
		25. Payment Distribution		
		Provider	Patient	
		26. Date approved		

PROVIDER BILLING FOR PATIENT SERVICES BY PHYSICIANS
MEDICAL INSURANCE BENEFITS - SOCIAL SECURITY ACT
(Use this form only where the provider has billing arrangement to collect physician charges for individual patient care pursuant to agreement with the physician.)

Form Approved
 Budget Bureau No. 72-R747

1. PATIENT'S LAST NAME	FIRST NAME	MI	2. SEX <input type="checkbox"/> M <input type="checkbox"/> F	3. HEALTH INSURANCE CLAIM NUMBER
4. PATIENT'S ADDRESS (Street number, City, State, Zip Code)			5. DATE OF BIRTH	6. MEDICAL RECORD NO.
7. NAME AND ADDRESS OF PROVIDER				7a. PROVIDER NO.

8. If the patient wishes to authorize release of information about this claim upon its request to another organization which provides health insurance for him, or to his State medical assistance agency, please give the following information.

INSURING ORGANIZATION OR STATE AGENCY NAME AND ADDRESS	POLICY OR MEDICAL ASSISTANCE NUMBER
--	-------------------------------------

9. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment below.

SIGNATURE <input type="checkbox"/> CONTAINED IN PROVIDER'S RECORD	SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)	DATE
--	--	------

10A. DATE OF EACH SERVICE	B. PLACE OF SERVICE (1)	C. FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES	D. PHYSICIAN IDENTIFICATION INFORMATION	E. CHARGE FOR PHYSICIANS SERVICES	LEAVE BLANK
			NAME OF PHYSICIAN/DEPARTMENT		
			TOTAL CHARGE PERCENT OF CHARGE		
			NAME OF PHYSICIAN/DEPARTMENT		
			TOTAL CHARGE PERCENT OF CHARGE		
			NAME OF PHYSICIAN/DEPARTMENT		
			TOTAL CHARGE PERCENT OF CHARGE		
			NAME OF PHYSICIAN/DEPARTMENT		
			TOTAL CHARGE PERCENT OF CHARGE		
			NAME OF PHYSICIAN/DEPARTMENT		
			TOTAL CHARGE PERCENT OF CHARGE		

(1) CODES: IH-INPATIENT HOSPITAL, OH-OUTPATIENT HOSPITAL, ECF-EXTENDED CARE FACILITY, H-HOME HEALTH AGENCY.

11. DIAGNOSIS AND CONCURRENT CONDITIONS	TOTALS	\$	
	Amount paid by Beneficiary		
12. EMPLOYMENT RELATED (If "Yes," give name and address of employer) <input type="checkbox"/> YES <input type="checkbox"/> NO	Any unpaid Balance		

13. PROVIDER CERTIFICATION: The physicians who performed the services described above have authorized the provider to accept assignment and receive payments in their behalf (and such authorizations are on file and still in effect.)

SIGNATURE OF PROVIDER REPRESENTATIVE	DATE
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430. PROVIDER BILLING FOR PATIENT SERVICES BY PHYSICIAN (FORM SSA-1554)

Form SSA-1554 is issued in single sheets (SSA-1554) and in two-part carbon interleaved sets (SSA-1554(2)). These are used to bill for physicians' services in a hospital where:

1. The beneficiary assigns payment to the physician.
2. The physician agrees that the reasonable charge as determined by the intermediary will be the full charge for services rendered.
3. The physician has authorized the hospital to accept the assignment and collect the payment on his behalf.
4. The physicians' services are not billed on the SSA-1453 or SSA-1483.

The hospital, in order to minimize form completion, should use the SSA-1453 or SSA-1483 to bill for physicians' services where this is permitted under the procedures which follow and if this is consistent with the hospital's charging practices.

No billing for physician's services should be filed unless the patient has Part B coverage.

For Inpatient Services. When Part A benefits are payable, the hospital may, if consistent with its usual charging practice, combine the physician's charge for inpatient services in the fields of radiology and pathology with the hospital's charge for the service. The single charge can then be billed on the SSA-1453. Services of the other physicians for whom a hospital is billing would continue to be billed on the SSA-1554. All physicians in the radiology or pathology department, for whom the hospital will bill, must agree, by department, to the single-charge billing method before this method can be used.

When no Part A benefits are payable, the hospital may submit inpatient radiology and pathology charges on form SSA-1483 together with charges for other Part B services. Where the hospital had used the SSA-1554 when Part A benefits were payable, it would continue to use this form, rather than the SSA-1483, during the period when Part A benefits are no longer payable. (The payment to the hospital under Part B for the hospital component of radiology and pathology service remains subject to the usual \$50 deductible and 20 percent coinsurance although the charge for the physicians' services in these fields is reimbursed at 100 percent of the reasonable charge.)

For Outpatient Services. Physicians' charges for outpatient services can be billed on the SSA-1483 as part of the hospital's total charge for the service. The SSA-1554 must be used, however, to bill for any physicians' services for outpatient psychiatric treatment.

General. The Part A intermediary will reimburse the hospital for all Part B physicians' charges which are billed on the SSA-1453 or SSA-1483. The Part B carrier will reimburse the hospital for charges which are billed on the SSA-1554. The SSA-1554 will be sent directly to the Part B carrier and will not be routed to the Part A intermediary.

Where the hospital does not wish to accept an assignment for a hospital-based physician and that physician is not billing directly by form SSA-1490, the hospital should furnish the patient with a fully itemized bill identifying each physician, the charges for his service, dates of service and procedures, or furnish equivalent information in Part II of the SSA-1490 (Request for Medicare Payment). Inform the patient that he may claim reimbursement by submitting an SSA-1490 with the itemized bill attached or with the itemized bill information furnished in Part II.

Where the hospital completes Part II of the SSA-1490, it should show the physician performing each service in item C and the authorized official of the hospital should sign in item 14 (ordinarily the signature space for the physician) showing the capacity in which he signs. A stamp signature is acceptable. (In the case of physicians' services included in a hospital charge collected from the patient for outpatient services, the hospital should submit a bill to the program on behalf of the patient on the SSA-1483.) Do not use forms SSA 1554, 1453, or 1483 to report the services where the physician wishes the medical insurance payments to be made directly to him. Inform that physician that he and the patient may complete a request for payment (form SSA-1490) for that purpose.

Physicians' Authorizations. The following is a sample of an authorization for use by providers in connection with provider billing for physicians' services. **A one-time execution of this authorization is all that is necessary by each physician.** The authorization should be retained in the provider's files.

"I hereby authorize the (name of institution) or any of its duly authorized administrators to accept on my behalf any assignment made by any individual who receives medical treatment from me at the (name of institution) of the amount payable to such individual under Part B of Title XVIII of the Social Security Act and to receive on my behalf any payments which may be made pursuant to such assignment. It is understood and agreed that the reasonable charge which will serve as the basis for payment in accordance with the terms of such assignment shall be the full charge for the services."

An additional statement should also include the individual arrangements agreed upon by the provider and the physician governing the conditions of withdrawing the authorization.

430.1 Completing Items on Form SSA-1554.--

- Item 1. Patient's Name.--The patient's name should be the same as that shown on his health insurance card with the last name shown first.
- Item 2. Sex.--Complete this block as an aid to patient identification.
- Item 3. Health Insurance Claim Number.--Enter the health insurance claim number shown on the patient's health insurance card or hospital billing form.
- Item 4. Patient's Address.--Show the address of the patient or his authorized representative. If the patient is deceased, show the name and address of the representative or, in the event there is no representative, his next of kin.
- Item 5. Date of Birth.--Complete this block if possible but if only the year of birth is known, show the year. While the date of birth is useful as identification, transmit the form without it if this information is not readily available.
- Item 6. Patient's Medical Record Number.--Show the patient's medical record number if one is assigned by the provider.
- Items 7 and 7a. Provider Identification.--Enter the name and address of the hospital in item 7 and the assigned health insurance provider number in item 7a. These entries may be stamped or preprinted.
- Item 8. Complementary Coverage Information.--If information about the claim is to be sent to a complementary insurer at the patient's request and the hospital does not object, enter the name and address of the health insurance company or organization, if any, which furnishes complementary health insurance to the patient. Also, show the insurance policy number in the appropriate block of this item. If the patient is a recipient of State medical assistance, enter the name and address of the welfare agency which pays the patient's assistance benefits and the patient's case number in this item. This information is needed to authorize the carrier to release information about the Medicare claim to the complementary insurer.

If the patient has some type of complementary insurance or medical assistance but the information required to complete this item is not available, the claim may be held a few days to secure the information.

Item 9. Authorization and Signature.--Have the patient or his authorized representative read the statement on the form or the statement in the hospital admission record if the hospital uses the alternate signature procedure (see §§ 270ff.). If the hospital obtains the signature on its own form, the box in this item of form SSA-1554 should be checked to indicate that the patient's request for payment is on file.

Where the provider uses an SSA-1554 continuous-feed form, it is not necessary that the patient's signature actually appear on the form. However, each group of the forms when forwarded should be accompanied by a covering letter which includes the following:

"I certify that the required patients' signatures (or where applicable, appropriate signatures on behalf of patients) are on file, that the physicians performing the services described have authorized the provider to accept assignments and receive payments in their behalf (and such authorizations are on file and still in effect) and that the information on the enclosed claims is correct."

Where a facsimile signature is provided on the form, the covering letter need only certify that the required patients' signatures or, where applicable, appropriate signatures on behalf of patients are on file.

All other items on the continuous-feed form should be completed in accordance with these instructions.

If the patient cannot sign his name because of his physical or mental condition, another person may sign on his behalf; e.g., John J. Jones by Jack A. Smith. The address of the signer should be entered next to his signature. (See § 271 for who may file a payment request.)

Briefly explain why the patient did not sign the form himself and show the relationship of the signer to the patient. This explanation should be retained in the hospital's file if the signature is obtained on the hospital's own record. If the signature is on form SSA-1554, the explanation should accompany or be included on the billing form.

The statement should be read to a patient who signs by mark. A signature by mark should be witnessed by a person who knows the patient. Enter the name and address of any person witnessing a signature by mark.

Item 10A. Date of Service.--Inclusive dates may be shown only where the provider and physician arrange to use the optional or per diem method to bill charges (see § 430.2) or where the identical services and charges are being billed under the item-by-item method.

Inclusive dates should not overlap:

1. Two calendar years;
2. September and October (because of the special carryover deductible feature described in § 246);
3. Months before and after the beneficiary was entitled;
4. March and April 1968 where the charges are for inpatient radiology and pathology. Where the combined billing method is used for April 1968 and subsequent months, the services shown on the SSA-1554 should end with March.

Item 10B. Place of Service.--Enter codes "IH" for hospital inpatient, "OH" for hospital outpatient.

Item 10C. Surgical or Medical Procedures.--Except where the optional or per diem method is used in determining physicians' charges, show the surgical, laboratory, x-ray, and other procedures performed for each date during the billing period. The procedures should be clearly identified by the use of standard nomenclature such as in "Current Medical Terminology," "Standard Nomenclature of Operations and Disease," and "Current Procedure Terminology."

Where the per diem method is used, show:

1. The number of days billed, and
2. The per diem rate, e.g., 20 days, each \$3.16.

Item 10D. Physician Identification Information.--Where the item-by-item method of billing is used, show the name of the physician for whose services the hospital is billing. Upon arrangement with the intermediary, billing may be in the name of the hospital department head.

Where the optional or per diem methods are used, enter the name of the department associated with the physician's services; e.g., x-ray, emergency room, or laboratory. However, any services to inpatients by a physician in the fields of radiology or pathology must be separately identified if performed in a department which also bills for other physicians' services. (See § 430.2.)

This block may be left blank for the per diem method where the same per diem rate is used for the entire hospital.

Total Charge and Percent of Charge.---These two blocks are used only where the physician and the hospital have agreed, with carrier approval, to use the optional method. When using the optional method to bill, the provider should show in the "total charge" block the combined charge for the provider and physician services of the department shown in the block immediately above in this item. In the "percent of charge" block, show the approved percentage of the total department charge.

Item 10H: Charge for Physicians' Services.---Enter the money amount attributable to physicians' services. Where the optional or per diem method is used, charges for inpatient services in the field of radiology or pathology should not be combined with charges for other physicians' services. Total all physicians' charges and enter the amount in the "totals" block. Show any part of the \$50 deductible and coinsurance paid by the patient and subtract the amount paid from the total charges.

Item 11. Diagnosis and Concurrent Conditions.---Show the most significant of the conditions first in entering diagnosis. Use recognized nomenclature such as that in "Current Medical Terminology," "Standard Nomenclature of Diseases and Operations," and the American Psychiatric Association's "Diagnostic and Statistical Manual," etc. Show any concurrent conditions associated with the primary diagnosis.

Where only diagnostic services are rendered and the diagnosis or chief complaint is not known, show the patient's presenting complaint.

Item 12. Employment Related.---Indicate if the condition is or may be employment related; give the name and address of the employer, if known. Payment will not be made where there is a reasonable expectation that the services are covered under workmen's compensation, e.g., where a workmen's compensation claim is pending. (See §§ 289ff. for detailed policies where there is a possibility of workmen's compensation.)

Item 13. Provider Certification, Signature, and Date.--The signature of the hospital representative serves as a request for payment on behalf of the physician and is also a certification that proper authorizations are on file and are still in effect. A stamped signature is acceptable. This signature can be covered with a blanket authorization where continuous-feed forms are submitted. See item 9 above.

430.2 Description of Item-by-Item, Optional, and Per Diem Methods for Physicians' Components.--When the item-by-item method is used, the hospital and physicians determine a schedule of separate identifiable charges for each procedure. This schedule is filed with the Part A and Part B intermediaries after agreement is reached with them regarding the appropriateness of all charges. (See § 255.)

A detailed reporting of the surgical or medical procedures is required to enable intermediaries to approve and make payment for physician services under supplementary medical insurance (Part B) in accordance with the schedule of charges established by the provider and physician. Under this method of determining the physician's charge, an itemization of services is necessary.

Under the optional method, the charges for services of a provider-based physician are determined by applying a single uniform percentage of the combined charge for hospital and physician services. The percentage established by the hospital and the physician must be approved by and filed with the intermediaries and will be used in determining the charge for physician services.

Where the optional method is followed, it is not necessary for providers to identify the surgical or medical procedure in item 10C of the Provider Billing for Patient Services by Physicians. It is sufficient to indicate the department by name, i.e., laboratory, radiology, etc., in item 10D. The total combined departmental charge for each department and the applicable single uniform percentage must be entered in column 10D.

Under the per diem method, a per diem rate, representing a daily charge for all physicians' services rendered in the entire hospital or for physicians' services performed in individual departments, is submitted by the hospital and approved by the intermediaries. It can thereafter be used either as part of the hospital's total charge for the service or be billed separately on the SSA-1554. The per diem method is approved only where the physician's charge cannot be established in any other way.

450. PROCEDURES FOR SUBMITTING INPATIENT BILLING IN NO-PAYMENT SITUATIONS

The benefits days available to a beneficiary depend on the status of his utilization of services during the "spell of illness" as described in § 215 and the lifetime reserve days as described in § H216. Submission of bills by hospitals for all stays, including those for which no payment can be made, assists the intermediary and Social Security Administration in maintaining utilization records and determining remaining eligibility.

Hospitals should submit inpatient billing forms in the following situations in which no program payment can be made:

- a. For the period after the date benefits were exhausted. This means that lifetime reserve days were exhausted or the patient elected not to use them;
- b. When services are not covered;
- c. When workmen's compensation paid, or can be expected to pay the entire bill;
- d. For the period beginning with the fourth day after a utilization review committee finding precludes further payment;
- e. When a National Institutes of Health grant paid or will pay the entire bill;
- f. When the patient or his representative refuses to request that payment be made on his behalf (see § 270);
- g. When the physician refuses to make an otherwise required certification for a reason other than lack of medical necessity (see § 273.1).

Do not submit a billing form where the entire billing period represents charges for which no payment can be made and the beneficiary is still a patient of the hospital at the end of the billing period. Only one billing form need be completed for such cases, regardless of the length of time involved, and this form is to be completed after discharge or death. The information to be entered on the billing form is limited to identifying information, critical dates, and essential statistical data.

Where the stay begins as noncovered and ends as covered, separate bills are required. For this situation the billing form for the noncovered period must be fully completed.

Completion of Items. When submitting bills falling in categories a through e above, items 1, 3, 4, 7, 8, 9, 13, 14, 17, 18, 19U, 20, 25, and 33 are the only items required.

In item 30 of form SSA-1453, give the reason for no payment; e.g., Benefits Exhausted, Workmen's Compensation, National Institutes of Health, Noncovered Services, Utilization Review.

Categories f and g are cases in which utilization is chargeable against the patient, even though no program payment is made; therefore, a fully completed bill must be prepared. In item 30 of form SSA-1453, enter "Refused Payment" or "Refused Certification" as the reason for no payment.

If the patient subsequently requests payment or the physician subsequently makes the necessary certification, reproduce a copy of the submitted bill. Cross off the entry "Refused Payment" or "Refused Certification" and enter "Patient Requested Payment" or "Physician Certification Obtained."

Covered and Noncovered Days. If a hospital reports covered and noncovered days on the same form, all items on the form should be completed and the charges for noncovered days should be shown in the "Noncovered Charges" column. Only covered days should be shown in "Covered Days," item 28. The hospital, except where benefits have been exhausted, should include the appropriate explanation of the reason no reimbursement is being claimed in the "Computation of Interim Payment" item.

460. PROCEDURE FOR SUBMITTING CORRECTED BILLS

The hospital may find that a bill already submitted is incorrect. This might happen, for instance, where late charges were not received at the time of the first billing or where the patient replaced blood after the first billing.

It is not necessary to submit a corrected SSA-1453 unless total inpatient charges change by more than \$10, or the interim cost reimbursement by more than \$1. However, a corrected bill should be submitted regardless of the amount of change in charges or cost reimbursement if the number of inpatient days, the inpatient deductible, or the blood deductible is changed. No tolerances are provided for services billed on a SSA-1483.

To correct a previously submitted bill, the hospital should reproduce a legible copy of the submitted bill. The necessary corrections should be made in red in the appropriate item. The corrected bill should be marked "DEBIT--ADJUST" in the upper right margin.

To cancel all the charges on a previously submitted bill, reproduce a legible copy and mark it "CANCEL ONLY" in the upper right margin. An explanation for the correction should be given on the reverse of the bill.

Submit the annotated copy of the bill to the intermediary.

Billing by Nonparticipating Hospitals

(Sections 470, 471, 472, and 473 provide instructions for hospitals who have elected to bill the program. Section 474 provides general information for hospitals not electing to bill the program. See § H208 for the special provisions for payment to the patient under hospital insurance (Part A) for inpatient services furnished after June 30, 1966, to patients admitted before January 1, 1968; § H202 for the 1967 amendment provisions on emergency hospitals; and §§ 202ff. for documentation of emergency claims.)

470. HOSPITALS ELECTING TO BILL THE PROGRAM--General

This section and §§ 471-473 are directed to those hospitals who elect on a calendar-year basis after 1967 to bill the program for all emergency services.

The billing instructions in §§ 400-460 apply to nonparticipating hospitals except as modified by instructions below.

In inpatient emergency cases, the hospital will receive Part A payment for the actual or assumed cost of services for the duration of the emergency, subject to the days available for payment, the inpatient deductible remaining in the spell of illness, and any applicable co-insurance. Cost is determined by the intermediary based on information furnished by the hospital.

In outpatient emergency cases, the hospital will receive 80 percent of the actual or assumed cost for outpatient services after March 31, 1968, subject to the Part B deductible.

In nonemergency cases, the hospital or the patient may be reimbursed for certain ancillary services under Part B at the rate of 80 percent of reasonable charges, subject to the Part B deductible.

471. BILLING FOR EMERGENCY AND NONEMERGENCY INPATIENT SERVICES

Emergency

For inpatient emergency admissions, the hospital will complete SSA-1453, Inpatient Hospital and Extended Care Admission and Billing, and follow the admission and billing procedures in §§ 202ff. and 330.

Nonemergency

If the hospital which elects to bill the program believes that the services were not of an emergency nature, it should use form SSA-1483 to bill for covered Part B services furnished after December 31, 1967. See § 420C for inpatient services which are covered under Part B.

The hospital may collect the entire charge from the patient and the patient will receive any reimbursement due from the intermediary or the hospital may take an assignment and have the benefits paid to it. If the hospital wishes to be paid by the program, it may collect any remaining Part B deductible and coinsurance from the patient, and should enter the words "I accept assignment" in the Remarks item of SSA-1483. The hospital should submit the SSA-1483 to the same intermediary which pays for emergency services.

If the hospital prefers not to complete the billing form, it should give the patient an itemized bill and direct him to file his claim through the social security district office. Payment will be made directly to the patient in such cases by the same intermediary.

472. PART B PAYMENT FOR DISALLOWED EMERGENCY INPATIENT CLAIMS

If part or all of the inpatient emergency claim is disallowed and the hospital billed the program for such services, the hospital will ordinarily be paid for the ancillary services covered under Part B with no additional evidence required. However, the intermediary may pay the patient if the hospital enters the words "no assignment" in item 30 of the SSA-1453. (See § 420C for inpatient services which are covered under Part B.)

473. BILLING FOR EMERGENCY AND NONEMERGENCY OUTPATIENT SERVICES

The hospital should use the 8/66 version of the SSA-1483 to bill for outpatient services furnished after June 30, 1966, and before April 1, 1968, and the 1/68 version for services furnished after March 31, 1968.

Outpatient emergency coverage is described in § H202.2. Emergency diagnostic services furnished before April 1, 1968, should be shown in the "Hospital Plan Charges" column of the 8/66 version of the SSA-1483. Therapeutic and nonemergency diagnostic services should be shown in the "Medical Plan Charges" column of the SSA-1483. For services furnished after March 31, 1968, the 1/68 version of the SSA-1483 should be used. See §§ 420ff. for instructions on completing this form. Both emergency and nonemergency services are reported on the same form.

Outpatient emergency and nonemergency coverage partially duplicate each other. The hospital should consider the following points in deciding whether to claim payment for emergency services.

Emergency Services. Only diagnostic services are covered until April 1, 1968. After March 31, 1968, services are covered as if furnished by a participating hospital, e.g., blood, non-self-administered drugs, etc. All these services are covered under Part B after March 31, 1968. (See § H230.) The hospital need not meet the conditions of

participation for the services furnished. Payment is on an actual or assumed cost basis. The payment is 80 percent of the actual or assumed cost less the applicable deductible to be met (\$20 for a 20-day diagnostic study period before April 1, 1968; \$50 for the calendar year after March 31, 1968).

Nonemergency Services. The following nonemergency services are covered under Part B. The hospital must meet the conditions of participation for laboratory and x-ray services. The payment is 80 percent of the reasonable charges less the \$50 calendar year deductible to be met.

- A. Laboratory and other diagnostic tests;
- B. X-ray, radium, and radioactive isotope therapy including services of technicians;
- C. Surgical dressings and splints, casts, and other devices used for the reduction of fractures and dislocations;
- D. Prosthetic devices (other than dental) which replace all or part of an internal body organ, including replacement of such devices;
- E. Leg, arm, back and neck braces and artificial legs, arms, and eyes, including replacement as required because of a change in the patient's physical condition.

The nonemergency outpatient SSA-1483 is submitted by the hospital to the intermediary which pays the hospital for emergency services. The emergency outpatient SSA-1483 is submitted by the hospital to the social security district office.

474. HOSPITALS NOT ELECTING TO BILL PROGRAM.

If the hospital has not elected to bill the program for emergency services, the patient should be furnished an itemized bill and advised to file his claim through the social security district office. That office will obtain any documentation necessary to support a patient's claim that the services were of an emergency nature.

If an **emergency is established for inpatient services** for an admission after December 31, 1967, the patient will receive reimbursement under hospital insurance (Part A) for routine service charges at the rate of 60 percent and covered ancillary service charges at the rate of 80 percent, subject to the inpatient deductible and coinsurance provisions. (See § H202.1 for definitions of "routine" and "ancillary" services.)

If an emergency is established for outpatient services furnished on or after April 1, 1968, reimbursement to the patient will be under medical insurance (Part B) for 80 percent of reasonable charges for covered outpatient services, subject to the Part B deductible.

For nonemergency inpatient and outpatient situations, reimbursement to the patient will be under Part B for 80 percent of reasonable charges for certain ancillary services, subject to the Part B deductible. (See § 420C for covered nonemergency inpatient services and § 473 for covered nonemergency outpatient services under Part B.)

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ADDENDUM FOR HOSPITALS USING THE PERIODIC
INTERIM PAYMENT METHOD OF REIMBURSEMENT

I. SUMMARY OF PERIODIC INTERIM PAYMENT METHOD OF REIMBURSEMENT
AND EFFECTIVE DATE

The periodic interim payment (PIP) reimbursement method for hospital inpatient services is available to all types of participating hospitals meeting these requirements: (1) total Medicare payment for inpatient services computed under the new method is at least \$25,000 on an annual basis, (2) the hospital has filed with its intermediary at least one completed cost report under the Medicare program, and (3) the intermediary is assured that the hospital has the continuing capability of maintaining in its records the cost charge, and statistical data needed to accurately complete a Medicare cost report on a timely basis.

Payment under this method may be made for services furnished on or after January 1, 1968. Any hospital that establishes to the satisfaction of the intermediary that it meets these requirements has the option to request the intermediary to make payments under this method.

The main features of the new method are:

- A. The intermediary will determine a fixed periodic interim payment, generally weekly. (See Section II.) This payment will approximate the cost of the average level of Medicare inpatient services rendered by the hospital during the payment interval. The intermediary will disburse these payments on designated days without regard to individual billings from the hospital. A hospital can request that the payment be computed somewhat differently to reflect a significant quarterly variation in Medicare utilization. (See Section III.C.)

Payments will be recomputed at regular intervals so that the interim payments will approximate actual costs as closely as possible. (See Section III.D.) In addition, a hospital may at any time request and be allowed an increase in the payment amount where it presents satisfactory evidence for the increase to the intermediary. Likewise, the intermediary will at any time adjust the payment where it has evidence that actual costs or Medicare utilization has dropped significantly below the computed rate. (See Section III.F.)

- B. Present Medicare inpatient hospital billing forms will continue to be used. A hospital will report admissions of Medicare patients to its intermediary under existing procedures. Upon discharge, the hospital will be required to furnish only limited data, including that data needed to update the Medicare patient's utilization record. In all cases the hospital

will attach a copy of its regular bill or other form customarily furnished to all patients upon discharge. (See Section VI.C.)

- C. A status verification procedure will be established in which hospitals will be contacted by intermediaries on a regular, scheduled basis regarding any admission notice more than 30 days old as of the status verification date established by the intermediary. This procedure is needed to assure the timely reporting of Medicare admissions and discharges to intermediaries, to provide current and continuing indications of the reasonableness of the periodic interim payment amounts, and to furnish needed program data. (See Section VI.D.)
- D. As at present, hospitals have to complete the Hospital Statement of Reimbursable Cost for each reporting year.
- E. Hospitals and their intermediaries will continue to have the same relationships under PIP as under other methods of interim reimbursement. From time to time, as they now do, intermediaries will visit hospitals to review some of the hospital's records of Medicare beneficiaries to verify that the services provided during the period reported to the intermediary were medically necessary covered services. The intermediary will also periodically review the financial and statistical data being accumulated by the hospital to be sure that the data are accurate and sufficient to permit the timely completion of the cost report. The program will rely on the hospital to maintain all of the data pertinent to inpatient services and which are needed to complete the required cost report. The kinds of charge and statistical data are discussed in the instructions for the preparation of the Hospital Statement of Reimbursable Cost (Form SSA-1563) and are largely determined by the method of apportionment (Departmental Method or Combination Method) that the hospital elects as the basis for the apportionment of its costs under Medicare. In addition to keeping identifiable charge data for inpatient services and outpatient services, a hospital electing to be reimbursed under the Departmental Method must keep identifiable records of Medicare charges and total charges for ancillary services by department. A hospital electing to be reimbursed under the Combination Method must maintain identifiable records of Medicare charges and total charges for ancillary services but may do so in the aggregate without regard to any departmental breakdown.

The new method does not require any change in the manner of record keeping or the kinds of information the hospital now maintains for Medicare purposes providing it yields accurate information under existing requirements. As under present regulations and procedures, cost data must be based on an approved method of cost finding and on the accrual basis of accounting.

Of course, intermediaries will continue to work with hospitals to assure that the hospital's records properly reflect all of the needed cost and charge data. Thus, based on their own cost and statistical data, hospitals will complete cost reports which become the basis for the final settlement, required retroactive adjustment, and required audits.

The PIP method of payment is a significant step toward attaining simplification while maintaining effective and efficient administration. It will result in general improvement and cost savings to hospitals and in program administration. These hospitals paid under the new method will avoid any financial burdens by receiving funds quickly after providing services and can achieve better management through improved financial planning.

Effective Date

An appropriate time to implement this method is the beginning of the hospital's next succeeding reporting year but not earlier than January 1, 1968. However, where a hospital elects to be paid under the new method subsequent to the beginning of its reporting year, it may do so starting at the beginning of any month. This may be done only where the hospital demonstrates to the satisfaction of the intermediary that it has adequate financial and statistical data pertinent to inpatient services and which is needed to support the timely preparation and submission of a complete and accurate cost report covering the hospital's entire current reporting period.

Where a hospital newly participating in the medicare program elects to be reimbursed under the new method the intermediary will evaluate the hospital's ability to meet the criteria for availing itself of the new method, except for the criterion regarding the filing of its initial cost report under the medicare program. The intermediary will submit a report of its evaluation and its decision to SSA.

II. PAYMENT INTERVALS

While the law provides that interim payments shall be made no less often than monthly, experience under the program strongly justifies payment to hospitals at more frequent intervals. Payments are made on a weekly basis unless the hospital at its option, requests the intermediary to make payments at fixed intervals of more than one week but not less often than monthly. Payments on a weekly basis are recommended in order to avoid placing any financial burden on hospitals by providing funds as nearly as possible after the time of providing services.

III. PERIODIC INTERIM PAYMENT COMPUTATION

A. Hospitals With Experience Under the Program

Before making payment under the PIP method, the intermediary will compute the amount per inpatient day which reflects the

hospital's anticipated costs of providing covered services (1) during the forthcoming reporting period where payments under the new method are effective with the beginning of the hospital's reporting year, or (2) during the current reporting period where the intermediary approves the hospital's election to be paid under the new method subsequent to the beginning of its reporting year. Where an intermediary is currently making interim payments on a per diem basis, a projection from the current rate is appropriate.

Some hospitals received prior interim payments on the basis of a percentage of the hospital's charges for services rendered to beneficiaries. In such cases, the intermediary will convert the recent payments made on this basis to the equivalent amount per inpatient day. (Recent payments refer to payments in the immediately preceding 3-month period.) Such a conversion to an amount per inpatient day provides a satisfactory base from which to make a projection of the anticipated costs per inpatient day of providing services during the forthcoming reporting period. The intermediary will also compute a per diem amount representing the deductible and coinsurance amounts which are beneficiary responsibilities. This is best determined from data reported on the most recent Hospital Statistical and Reimbursement Report (HS&R). Hence, the difference between the cost per inpatient day and the deductible and coinsurance amount per inpatient day represents the program responsibility on a per inpatient day basis. The intermediary will project the annual utilization of the hospital's services by medicare beneficiaries based on data from the most recent HS&R report or from the hospital's and intermediary's own records where the intermediary believes a more accurate computation will result.

Hence, the PIP can be computed as follows:

$$\frac{(C - B) \times D}{PI} = \text{PIP}$$

C = cost per inpatient day

B = beneficiary deductible and coinsurance amount per inpatient day

D = projected annual medicare days

PI = payment interval factor

Hospitals would continue to charge and collect from beneficiaries the deductible and coinsurance amounts which are beneficiary responsibilities under the law.

Example A

Hospital A is currently being reimbursed at the rate of \$37 per day. Based on the hospital's most recent HS&R report it

is determined that beneficiary deductible and coinsurance amount per inpatient day is \$3 (Item 8 Inpatient Deductible + Item 9 Inpatient Coinsurance ÷ Item 13 Accommodation Days). The hospital anticipates a 10 percent increase in costs and estimates 4,000 medicare days for the reporting period.

Using the above formula:

$$\frac{(C - B) \times D}{PI} = PIP$$

$$\frac{(\$37.00 + 10\% \text{ of } \$37.00 - \$3.00) \times 4,000 \text{ days}}{52} = PIP$$

$$\frac{\$150,800}{52} = \$2,900$$

Of course, where the hospital requests payment on a bi-weekly or semi-monthly basis the divisor would be 26 or 24, respectively.

B. New Hospitals

When a hospital first enters the program no cost experience will be available on which to base payments. In such cases, the intermediary will use the following methods to determine an appropriate payment:

1. Where there is a hospital or hospitals for which payments have been established and which are comparable in substantially all relevant factors to the new hospital, the intermediary will base the payments to the new hospital on the costs and medicare utilization of the comparable hospital.
2. If there are no substantially comparable hospitals from which data are available, the intermediary will determine a payment based on budgeted or projected costs of the new hospital and estimated medicare utilization of services.

The recomputation of periodic interim payments, as provided hereafter, apply so that adjustments to the periodic interim payment may be based on the latest information available.

C. Alternative Method of Computing Periodic Interim Payments Where There Is a Significant Seasonal Variation in Utilization of Services

Where a hospital's inpatient medicare experience shows significant seasonal variation in utilization of services and the hospital requests PIP payments reflecting this variation in utilization, the intermediary may compute payments accordingly. In no case, however, is the intermediary to

recognize variations in utilization other than on a total quarterly basis starting with the beginning of the hospital's reporting year. The quarterly periods must correspond with the required quarterly recomputation periods.

Example B

Assume all of the facts presented in Example A. In addition the hospital's reporting year under medicare is the calendar year and its records for calendar year 1967 show medicare inpatient utilization as follows: January 1 - March 31, 1967, 35%, April 1- June 30, 1967, 20%, July 1 - September 30, 1967, 15%, October 1 - December 31, 1967, 30%. Accordingly, weekly payments during 1968 could be computed as follows:

$$\begin{array}{lcl} \text{1st Quarter} & = & \frac{35\% \times \$150,800}{13} = \$4,060 \\ \text{PIP} & & \end{array}$$

$$\begin{array}{lcl} \text{2nd Quarter} & = & \frac{25\% \times \$150,800}{13} = \$2,900 \\ \text{PIP} & & \end{array}$$

$$\begin{array}{lcl} \text{3rd Quarter} & = & \frac{15\% \times \$150,800}{13} = \$1,740 \\ \text{PIP} & & \end{array}$$

$$\begin{array}{lcl} \text{4th Quarter} & = & \frac{25\% \times \$150,800}{13} = \$2,900 \\ \text{PIP} & & \end{array}$$

Where a hospital requests PIP payments reflecting variations in utilization, its payments for the entire provider reporting year will be computed by the intermediary on this basis. However, the hospital may annually elect to receive payments for each reporting year on a straight line basis or on the basis reflecting variations in utilization where experience shows significant quarterly seasonal variations.

D. Recomputation Following Submission of Cost Report

Immediately after the receipt of the hospital's cost report for the preceding reporting period, the intermediary will recompute the PIP. This will be based on the reported inpatient cost data adjusted for such factors as would appropriately reflect the hospital's estimated cost of providing covered services to beneficiaries for the year following the period covered by the cost report. A projection of the deductible and coinsurance amounts which are the payment responsibility of beneficiaries will also be made by the intermediary and should reflect the appropriate corresponding adjustment factors applied in arriving at the hospital's estimated medicare costs, as well as the bad debt experience

of the provider. For example, assume the average deductible and coinsurance amount charged per medicare patient day during the prior year was \$3.25, 20 percent of the hospital's 10,000 patient days were medicare patient days and two percent of the deductible and coinsurance amounts were bad debts. For the ensuing year, the hospital estimates it will provide 12,000 patient days of care, estimates 20 percent medicare utilization and the same two percent deductible and coinsurance bad debt factor. Based upon these estimates the projected aggregate deductible and coinsurance amount will be:

\$3.25 x 2,400 patient days (2,000 + 20% increase) or \$7,800
less 2% bad debts, or \$7,644

Computation formula:

$$\frac{MC - DC}{PI} = PIP$$

MC = estimated medicare cost

DC = estimated beneficiary deductible and coinsurance payments

PI = payment interval

Example C

Hospital C which receives interim payments on a weekly basis submits its cost report for the preceding accounting year. After cost finding and apportionment in accordance with the Principles of Reimbursement for Provider Costs, it is determined that the cost of the 2,000 medicare inpatient days was \$100,000. For the ensuing year, the hospital estimates a 20% increase in medicare utilization and a 10% increase in costs. In addition, the deductible and coinsurance data in the example contained in the above narrative apply. Converting the aggregate medicare cost to an average cost per diem (for interim payment purposes only) a cost per inpatient day of \$50 (\$100,000 ÷ 2,000 days) is determined. Based on a realistic projection for the ensuing year, a cost of \$55 per day (\$50 + 10% increase) and utilization of 2400 days (2,000 + 20% increase), an estimated annual medicare cost of \$132,000 is computed.

Using the above formula:

$$\frac{MC - DC}{PI} = PIP$$

$$\frac{(\$55 \times 2400 \text{ days}) - (\$3.25 \times 2400 \text{ days less } 2\% \text{ bad debts})}{52 \text{ weeks}} = PIP$$

$$\frac{\$132,000 - \$7,644}{52} = \$2,391$$

E. Alternative Computation of Deductible and Coinsurance Factor (DC) of Formula

An acceptable alternative in projecting the DC factor in the formula would be the deductible and coinsurance payments paid by beneficiaries for the prior period adjusted upward or downward at the rate of \$40 per admission where a realistic change in medicare utilization is projected. For example, assume the deductible and coinsurance amounts collected from beneficiaries in the prior year was \$7500 and the hospital anticipated a 5% increase in medicare utilization, that is, from 2,000 medicare days to 2,100 medicare days. On the basis of the average length of stay for the aged in the hospital, in this example 14 days, an acceptable DC factor in the formula would be \$7,500 plus \$320. (The \$320 represents 100 additional medicare days \div 14 days average length of stay for the aged in this hospital \times \$40 or 8 \times \$40. The conversion of days to admissions should be rounded to the next highest number.)

F. Other Recomputations of Periodic Interim Payments

After the recomputation of the PIP based on cost report data projected, the hospital may at any time request and be allowed an appropriate prospective increase in the PIP, upon presentation of satisfactory evidence to the intermediary that costs or medicare utilization have increased. Likewise, the intermediary may at any time adjust the PIP if it has evidence that the hospital's actual costs or medicare utilization may have fallen significantly below the computed rate. A significant factor in evaluating the amount of the payment in terms of the realization of the projected medicare utilization of services is the timely submission to the intermediary of completed admission and billing forms. (See Section VI.) The intermediary will periodically reconcile the medicare days of utilization based on discharge data as reported on individual forms SSA-1453 or the status verification procedure with the estimated days of utilization used in computing the PIP payment. Any significant difference will be a factor for the intermediary to consider in making the required recomputations of prospective PIP payments.

Whether or not a hospital requests recomputation, the intermediary will recompute the PIP not less frequently than quarterly. Immediately after receipt of the hospital's cost report the intermediary will recompute the PIP on the basis of reported data without regard to the time interval elapsed

since the immediately preceding recomputation. Following the recomputation based on cost report data, the intermediary will resume its established schedule of recomputations. For example, General Hospital's reporting year ends December 31, 1967, and receives payments from its intermediaries on a weekly basis. It submits its cost report to its intermediary on February 20, 1968. The intermediary will recompute the PIP and make payment based on that report. Thereafter, it will recompute the PIP payment so that revised amounts can be disbursed starting with the first period following March 31, June 30, and September 30.

The overall objective in intermediary surveillance of the periodic payments is to assure payments approximating actual costs as closely as possible.

G. Lump Sum Interim Payments

The intermediary may make a lump sum payment to the hospital to bring past interim payments in line with costs where it has incurred significant expenditures not otherwise reflected in the PIP. Typically, this could occur where retroactive salary increases were disbursed by the hospital. PIP payments should not reflect retroactive costs; they are intended to approximate the actual cost for the payment interval for which they are made.

IV. OFFSETTING OF OUTSTANDING ACCELERATED PAYMENTS ON ACCOUNT

Accelerated payments on account will no longer be needed by any hospital receiving payments under the new method. The intermediary will commence to offset outstanding accelerated payments on account against bills submitted for prior period services and for which an accelerated payment on account had been made. It is expected that the offset will be fully accomplished simultaneously with the conclusion of payment based on individual billings covering services provided before the beginning of the reporting period for which the new method of payment to the hospital is put into effect.

V. REPAYMENT OF CURRENT FINANCING PAYMENT

The disbursement of current financing payments would be no longer required with the implementation of the new method of payment. Outstanding current financing payments should be repaid. Such repayments may be made by a payment from the hospital to the intermediary or on the basis of a reasonable schedule of reductions from the next succeeding PIP payments. In every instance, however, such amount must be fully repaid within 18 months following the receipt by the hospital of its first periodic interim payment under the new method of payment.

VI. HOSPITAL PROCEDURES

A. Notices of Admission

Notices of admission procedures are the same as described in Chapter III, except that the intermediary will identify cases which require the submission of bills showing discharge diagnoses and surgical procedures (see Section I.B.). Where the Report of Eligibility is the established method of advising the hospital, the Remarks section should indicate:

"Show Discharge Diagnoses and Surgical Procedures"
(or other appropriate notation)

All claims where the last digit of the patient's health insurance claim number is "0" or "5" will fall in this category. The admission copies of form SSA-1453 should be submitted to the intermediary within 24 hours after the patient is admitted.

B. Reporting and Billing Procedures for Patient Stays at Time of Transition or When Straddling Two Reporting Periods

1. Transition to New Method

The PIP method is effective only with **services rendered** beginning with the hospital's new reporting period but not earlier than January 1, 1968, or the beginning of any succeeding month where the intermediary approves the hospital's election to be paid under the new method. (See Section I.) Hospitals are required to submit form SSA-1453 covering services rendered through the end of the preceding month and will be paid under existing methods of payment for this period. The billings will be handled as regular interim bills and will be annotated "Still Patient" in item 25 of the SSA-1453. Subsequent billings for the same patient will be submitted without sending an additional notice of admission.

2. After Transition to New Method

Where a hospital is already receiving payment under PIP, it must submit two billing forms for each Medicare patient whose hospital stay straddles the old and new reporting years. This will require each bill to be completed as in C. below, except that the bill covering dates falling in the old reporting period should be annotated "Still Patient" in item 25 of the SSA-1453.

C. Completing Items on Billing Form SSA-1453 (See Exhibit 1)

Completion of the items on the SSA-1453 will be the same as under existing procedures except for the following special instructions:

1. Detailed billing on form SSA-1453 is not required by PIP hospitals. Entries in the Statement of Services Rendered in 100 percent of the billing forms should consist of the following:

- a. Line A--All information.
- b. Line G--Total accommodation charges and total noncovered accommodation charges.
- c. Line U--Total charges and total noncovered charges.
- d. Line V--Inpatient deductible.
- e. Line W--Blood deductible.
- f. Line X--Coinsurance.
- g. Line Y-- Total deductions.

2. Discharge or Current Diagnoses and Surgical Procedures items should be completed in all cases designated by the intermediary in the report of eligibility. (See A. above.)

3. Submission of Inpatient Bills

Bills should be submitted at discharge or death. Whenever the patient remains in the hospital, a bill should be submitted as of the fourth day after receipt by the hospital of an adverse finding by the utilization review committee, or when benefits are exhausted. In all PIP billings the hospital should attach a copy of the bill or other form that it customarily furnishes to all of its patients at time of discharge. "No payment bills" should be submitted as described in § 450.

Where bills are not submitted on a timely basis the intermediary will reduce prospective payments to conform to a lower level supported by the data shown on the monthly reports.

Corrected bills will be submitted in accordance with § 460 except that correction will be required only where there is a change in any of the reported data.

4. Completion and Submission of Form SSA-1484, Explanation of Accommodation Furnished

The hospital will complete SSA-1484, as described in § 412. If the special deduction described in § 210.1C is applicable, the intermediary will compute the accommodation differential and return the forms to the hospital showing the accommodation differential. The hospital will keep these records for use in preparing its cost report form.

D. Status Verification Procedure

Each hospital will be contacted by its intermediary on a regular scheduled basis, but not less often than monthly, regarding any admission notice more than 30 days old as of the status verification date established by the intermediary. The hospital should respond within a reasonable time. For example, under a semi-monthly or monthly status verification procedure, a hospital would be requested by its intermediary to confirm the admission notice of any Medicare inpatient whose admission occurred at least 30 days before the semi-monthly or monthly status verification date.

INPATIENT HOSPITAL AND EXTENDED CARE ADMISSION AND BILLING

HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

EXHIBIT I

Form Approved
Budget Bureau No.
72-RO734

1. Patient's last name		First name		MI	2. Sex <input type="checkbox"/> M <input type="checkbox"/> F	3. Health insurance claim number	
4. Patient's address (Street number, City, State, ZIP Code)					5. Date of birth		6. Medical record number
7. Date of this admission		8. Provider name and address (City and State)			9. Provider number		10. Attending physician
11. Dates of qualifying stay FROM		12. Qualifying and other prior stay information					
THRU							

If you have other health insurance or if your State Medical Assistance Agency will pay part of your medical expenses and you want information about this claim released to them upon their request, complete items 13 and 14.

13. Insuring organization or State agency name and address		14. Policy or medical assistance no.
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15. Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related medicare claim. I request that payment of authorized benefits be made on my behalf.

<input type="checkbox"/> Contained in provider's record	Signature (Patient or authorized representative) (Signature by mark must be witnessed)	Date
---	--	------

16. Admitting diagnoses (If employment related, also give name and address of employer)	Do not use this space	17. Discharge or current diagnoses (a) Primary Complete in 20% of cases* (b) Secondary	Do not use this space
---	-----------------------	---	-----------------------

18. Surgical procedures (Show date of each) Complete in 20% of cases*					
--	--	--	--	--	--

19. STATEMENT OF SERVICES RENDERED				Total Charges	Non covered Chg's	20. Statement covers period FROM		THRU
------------------------------------	--	--	--	---------------	-------------------	-------------------------------------	--	------

Blood pints furnished	Pints replaced	Not replaced	Charge per pint					21. Date guarantee of payment began	22. Date UR notice received
Accommodation				Days	Rate				
B. 1-Bed									
C. 2-3-4 Bed									
D. 5 or more Beds									
FOR HOSPITAL									
E. Intensive care									
F. Self care									
G. PIP total									
H. Operating room									
I. Anesthesia									
ONLY J. Outpatient services									
K. Blood administration									
L. Pharmacy									
M. Radiology									
N. Laboratory									
O. Medical, surgical and central supplies									
P. Physical therapy									
Q. Occupational therapy									
R. Speech therapy									
S. Inhalation therapy									
T. Other (Describe)									
U. TOTALS									
V. Inpatient deductible									
W. Blood deductible pts. @									
X. Coinsurance days () ()									
Y. TOTAL DEDUCTIONS									

29. I certify that the required physician's certification and recertifications are on file.		30. Remarks:		PIP per diem amounts \$
---	--	--------------	--	-------------------------

31. Reimbursement amount \$				FOR INTERMEDIARY USE			
32. Verified non-covered stays From		Thru		33. Non-pmt. code	34. Days used		

Signature of provider representative		Date forwarded	35. Approved by	Date approved
--------------------------------------	--	----------------	-----------------	---------------

(Intermediary completes this entry.)





DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

INPATIENT HOSPITAL ADMISSION AND BILLING
HOSPITAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

EXHIBIT 1

Form Approved
Budget Bureau
No. 72-R734

1. PATIENT'S LAST NAME			FIRST NAME		MI	2. HEALTH INSURANCE CLAIM NUMBER			
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)						4. DATE OF BIRTH		5. SEX <input type="checkbox"/> M <input type="checkbox"/> F	
6. HOSPITAL NAME AND ADDRESS				7. PROVIDER NO.		9. NAME AND ADDRESS OF ATTENDING PHYSICIAN			
				8. MEDICAL RECORD NO.					
10. DATE OF THIS ADMISSION			11. NAME AND ADDRESS OF ANY INSTITUTION FROM WHICH DISCHARGED DURING LAST 60 DAYS (If this hospital, give dates of stay)						
12. PAYMENT SOURCE FOR CHARGES TO PATIENT									
<input type="checkbox"/> SELF OR FAMILY			<input type="checkbox"/> BLUE CROSS BLUE SHIELD			<input type="checkbox"/> PUBLIC AGENCY (Give name)			
<input type="checkbox"/> PRIVATE INSURANCE			<input type="checkbox"/> EMPLOYER OR UNION			<input type="checkbox"/> OTHER (Explain)			
13. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.									
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)								DATE	
14. ADMITTING DIAGNOSIS						EMPLOYMENT RELATED <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, give name and address of employer	
15. DISCHARGE DIAGNOSES OR CURRENT DIAGNOSES (Primary illness and secondary or complicating illnesses)								Do not use this space	
Complete in 20% of cases *									
16. SURGICAL PROCEDURES (Related to primary illness and other—Show date of each)									
Complete in 20% of cases *									
17. STATEMENT OF SERVICES RENDERED				TOTAL CHARGES		NON-COVERED CHARGES		18. STATEMENT COVERS PERIOD FROM TO	19. TOTAL DAYS
ACCOMMODATION		DAYS	RATE						
A. 1-Bed				\$		\$			
B. 2-3-4 Bed								20. DATE GUARANTEE OF PMT. OR UR NOTICE RECEIVED	
C. 5 or more Beds								21. DATE BENEFITS EXHAUSTED	
D. Intensive Care									
E. Self Care TOTAL								22. <input type="checkbox"/> DISCHARGED	
F. WHOLE PINTS FURNISHED		NOT REPLACED	CHARGE PER PINT					<input type="checkbox"/> DIED <input type="checkbox"/> STILL PATIENT	
G. Operating Room								23. DATE DISCHARGED OR DIED	
H. Pharmacy									
I. Laboratory								24. COMPUTATION OF INTERIM PAYMENT	
J. Radiology								(Intermediary enters per diem rate here)	
K. Medical, Surgical and Central Supplies									
L. Anesthesia									
M. Inhalation Therapy									
N. Other (Describe)									
O. TOTALS				\$		\$		Reimbursement Amount \$ XXX	
P. Inpatient Deductible								FOR INTERMEDIARY USE	
Q. Blood deductible Pts. @								25. VERIFIED PRIOR STAY DATES	
R. Coinsurance								FROM TO	
S. TOTAL DEDUCTIONS								PROVIDER NO.	
I certify that the required physician's certification and recertifications are on file.								NONE	
26. SIGNATURE OF HOSPITAL REPRESENTATIVE				DATE FORWARDED		27. APPROVED BY		DATE	



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

INPATIENT PSYCHIATRIC OR TUBERCULOSIS HOSPITAL ADMISSION AND BILLING
HOSPITAL INSURANCE BENEFITS - SOCIAL SECURITY ACT

EXHIBIT 2
Form Approved
Budget Bureau
No. 72-R732

1. PATIENT'S LAST NAME			FIRST NAME		MI	2. HEALTH INSURANCE CLAIM NUMBER				
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)						4. DATE OF BIRTH		5. SEX <input type="checkbox"/> M <input type="checkbox"/> F		
6. HOSPITAL NAME AND ADDRESS			7. PROVIDER NO.			9. NAME AND ADDRESS OF ATTENDING PHYSICIAN				
			8. MEDICAL RECORD NO.							
10. ADMITTED TO ACTIVE CARE			11. NAME AND ADDRESS OF ANY INSTITUTION (including this institution) IN WHICH PATIENT RECEIVED INPATIENT CARE DURING LAST 60 DAYS (If this hospital, give dates of stay)							
12. NAME AND ADDRESS OF ANY PSYCHIATRIC OR TUBERCULOSIS INSTITUTION WHICH FURNISHED INPATIENT SERVICES AT ANY TIME DURING 90 DAY PERIOD PRECEDING EFFECTIVE DATE FOR HOSPITAL INSURANCE (If this hospital, give dates of stay)										
13. PAYMENT SOURCE FOR CHARGES TO PATIENT <input type="checkbox"/> SELF OR FAMILY <input type="checkbox"/> BLUE CROSS BLUE SHIELD <input type="checkbox"/> PUBLIC AGENCY (Give name) <input type="checkbox"/> PRIVATE INSURANCE <input type="checkbox"/> EMPLOYER OR UNION <input type="checkbox"/> OTHER (Explain)										
14. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made on my behalf.										
SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed)							DATE			
15. ADMITTING OR CURRENT DIAGNOSIS EMPLOYMENT RELATED <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, give name and address of employer.)										
16. DISCHARGE DIAGNOSES OR CURRENT DIAGNOSES (Primary illness and secondary or complicating illnesses)							Do Not Use This Space			
Complete in 20% of cases *										
17. SURGICAL PROCEDURES (Related to primary illness and other—Show date of each)										
Complete in 20% of cases *										
18. STATEMENT OF SERVICES RENDERED			TOTAL CHARGES		NON-COVERED CHARGES		19. STATEMENT COVERS PERIOD FROM TO		20. TOTAL DAYS	
ACCOMMODATION			DAYS		RATE					
A. 1-Bed										
B. 2-3-4 Bed										
C. 5 or more Beds										
D. Intensive Care										
E. S.W.C. TOTAL										
F. WHOLE BLOOD			PINTS FURNISHED		NOT REPLACED		CHARGE PER PINT			
G. Operating Room										
H. Pharmacy										
I. Laboratory										
J. Radiology										
K. Medical, Surgical and Central Supplies										
L. Anesthesia										
M. Inhalation Therapy										
N. Other (Describe)										
O. TOTALS										
P. Inpatient Deductible										
Q. Blood Deductible Pts. @										
R. Coinsurance										
S. TOTAL DEDUCTIONS										
I certify that the required physician's certification and recertifications are on file.										
28. SIGNATURE OF HOSPITAL REPRESENTATIVE					DATE FORWARDED		29. APPROVED BY		DATE	

FORM SSA-1485 (5-66) * Complete only where terminal digit of medicare beneficiary's health insurance number is "0" or "5."

A-18

Revision No. 2
12/67

For _____, 196__
(Month)

<u>I. IDENTIFYING INFORMATION</u>	<u>II. SUMMARY OF MEDICARE INPATIENTS</u>
1. Name of Hospital: _____	1. Inpatient count at end of last month _____
2. Address of Hospital: _____ _____	2. Plus admissions during month _____
3. Provider Number: _____	3. Less discharges during month _____
4. Date Forwarded to Intermediary: _____	4. Inpatient count at end of month _____
5. Intermediary Number: _____	

HI Number	Name of Patient	Date of Admission	Date of Exhaustion of Benefits	Date of Discharge
(A)	(B)	Month / Day (C)	Month / Day (D)	Month / Day (E)
1. <u>Census End of Prior Month</u>				
2. <u>Admissions During Current Month</u>				

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